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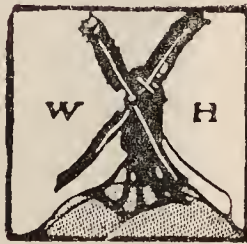
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MEDICINE
AND THE PUBLIC

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MEDICINE AND THE PUBLIC

BY
S. SQUIRE SPRIGGE
M.A., M.D. CANTAB.



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PREFACE

THE greater part of this book was published as a series of chapters in *The Lancet*, where the audience appealed to was mainly medical, and where the arguments for a more enlightened attitude towards the medical profession were not likely to meet with opposition. But the questions that are discussed are not such as interest medical men only ; indeed, I am not sure that they interest medical men mainly. The whole population of Great Britain is concerned in the quality of its medical service, and in the legislative and social conditions under which that service is rendered. In exceptional circumstances the truth of this is readily acknowledged. When a national crisis like the Boer War falls upon us we recognise the debt that modern life owes to the science of medicine. When a community is threatened with an epidemic disease, or when a port is invaded by some tropical pest, we see clearly enough the value of scientific prevention. But the public is not interested in the practice of medicine from day to day ; it is not concerned as to

the circumstances in which the medical profession, of which in emergencies it expects a great deal, does its work. It is natural that the medical profession, which ministers to the public in an intimate and ungrudging manner, should expect to find the public willing to see the calling of medicine placed upon a more secure and dignified basis than it now possesses. But it is evident that laws will not, and should not, be made in response to any sentimental claim, and that before a scheme for the improvement of medical practice obtains recognition in Parliament its promotion must be seen to be to the advantage of the public. I have endeavoured to show, when dealing with the disabilities and grievances of different sections of the medical profession, that reform would be undertaken in each case in the interests of the whole community, and if this does not appear from what I have written, I have failed to do justice to a very convincing series of facts. My hope is that, by bringing these facts before the public, a more widespread sympathy may be evoked for the difficulties which medical men undergo in the exercise of their professional duties.

I have written with some minuteness upon the education of the medical student, because this has become recently a matter of great importance. Medical science is advancing by gigantic strides,

encroaching in every direction upon provinces which were wont to be considered as definitely allocated to other sciences. But at the same time the public is vastly improved in general knowledge, and requires of those who advise it upon the special walks of life some recognition of this fact. The professional man can no longer, out of a superior learning, counsel his clients dogmatically and empirically. That is to say, for the medical man at the present day a larger general culture is required in addition to a more complicated and elaborate professional equipment. The older universities and the medical corporations have striven manfully to meet the calls upon them, while the recently-founded universities have taken care that science and medicine should be prominent among their faculties, and as a result the situation is a most interesting and instructive one to all interested in technical education.

The various circumstances which impede medical men in their professional work, and which serve to promote preventable disease, to maintain a high infantile mortality, and to keep the military and naval medical staffs undermanned, might be much improved by legislation, if the public would note where the calling of medicine is out of touch with the times and would insist upon the proper remedies. In the management of hospitals and in the mainte-)

nance of many charities the public and the medical profession are able to work with complete accord. It seems to me probable that a similar harmony would prevail between them throughout the usual relations of life if the public could appreciate more exactly what are the facts and ideals of the medical career.

I have endeavoured in this book to be brief.

S. S. S.

UNITED UNIVERSITY CLUB,

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CHAPTER I

THE CONSTITUTION AND SCOPE OF THE GENERAL MEDICAL COUNCIL

The Medical Profession and General Scientific Progress.—The Struggle for Registration.—The Medical Act of 1858.—The Powers of the General Medical Council.

THE story of the medical profession in England, Ireland, and Scotland alike is one of progress. During the last fifty years the art of medicine has been entirely revolutionised, every change in it being towards a transformation into an exact science. Fields of knowledge have broadened with the capacity to till them, tools have become more delicate and more precise, and the advances made in many of the provinces of exact learning other than medical have had an influence that cannot be over-estimated upon medical views. Consequently the scientific equipment of the medical man of to-day differs in countless respects from that of his grandfather.

The expansion of learning that has taken place in medicine has been going on in all other branches of knowledge, whether nearly allied to medicine or not. Where the sciences more directly ancillary to medicine are concerned the old boundaries between them and medicine have been removed. No one

can say exactly where chemistry stops and where physiology begins, what familiarity with electricity rightly appertains to the medical man's calling, or what knowledge of physics or of statistics should be presupposed in a medical practitioner. The significance of all this is very great and is not summed up in the least by saying that the medical student has nowadays much to learn. The many-sided and vast developments of science have, of course, changed the schemes of medical study, but they have done much more than this. They have altered the status of the medical man. For it has now come about that, instead of occupying, as he did, one peak of a tripartite eminence wherefrom the exponents of divinity, medicine, and law—"the learned professions"—were wont to survey an unlettered world, he has to submit to being classed with other practical workers who have an equal claim with him to be considered men of science. This should not, however, lead to any depreciation of the medical man, but only to an alteration of the point of view from which he is regarded by the public. With the spread of knowledge the number has increased of persons who can appreciate the difficulty of medical practice. These may not revere the medical calling as something too learned or too mysterious for their comprehension, but they respect it because of its scientific aims. The growing public acquaintance with scientific methods must lead to an improved estimate of medicine as long as medicine progresses. And medicine, being inextricably bound up with the ancillary sciences, must progress with them. The medical profession has nothing to fear from a more

enlightened public; on the contrary, the better acquainted the public becomes with the teachings of science the more certain are those who follow the calling of medicine to find many and powerful sympathisers. The day of the mystery-man is over; his proper place is in a novel.

The story of the recent rise of the medical profession to some extent accounts for its position in the public esteem, and so may be briefly outlined. Fifty years ago the medical profession was divided into two classes, the consultants—*i.e.*, the consulting physician and the operating surgeon—and the general practitioners. The division was more marked in England than it was in Scotland and Ireland, and had been much stricter in the Regency and in the following decades, inasmuch as the immediate effect of the passing of the Apothecaries Act in 1815 was to create an inferior order of general practitioners. Thackeray, with his wonderful accuracy when drawing social types, has revealed the situation in one sentence at the beginning of the second chapter of “Pendennis”:—

“Early in the Regency of George the Magnificent there lived in a small town in the heart of England, called Clavering, a gentleman whose name was Pendennis. There were those alive who remembered having seen his name upon a board, which was surmounted by a gilt pestle and mortar, over the door of a very humble little shop in the City of Bath, whence Mr. Pendennis exercised the profession of Apothecary and Surgeon, and where he not only attended gentlemen in their sick-rooms and ladies at the most interesting periods of their lives, but would

condescend to sell a brown-paper plaster to a farmer's wife across the counter or to vend tooth-brushes, hair-powder, and ladies' perfumery."

Old Pendennis was the typical product of the Apothecaries Act, and in his person the general practitioner cannot be said to have enjoyed any high social or scientific status. It is not meant to imply that old Pendennis was a fair example of the general practitioner up to the definite foundation of the medical profession, as it is now, by the passage of the first Medical Act in 1858. On the contrary, for thirty years before the passage of that Act the general practitioners, many of them holding diplomas from a Royal College and some being graduates of a University, had steadily improved their position and won their way to demanding the stability and official recognition which could only be ensured by passing a measure of registration.

The struggles which led to the passing of that Act were very acute, for public opinion was not agreed as to the advisability of it. The monopoly implied by registering certain medical men to the exclusion of others—even those who had not undergone proper training—was considered to be fraught with inconvenience if not with danger. In 1827 Mr. Henry Warburton, the Member for Bridport, a merchant and a business-like man, who later made his mark in six consecutive Parliaments as a Free-trader, presented a petition from the Royal College of Surgeons of England for an inquiry by the House into the management of that wealthy and influential corporation. The request of the College was acceded to, but no practical reform followed. A *fracas* in the

College building led to the formation by Thomas Wakley, then editing *The Lancet*, and some of his colleagues of an abortive scheme known as the London College of Medicine. The scheme was a failure from the beginning, but it contained in it two great ideas—the idea of one central governing body for the medical profession and of one entrance into the medical profession for all candidates. The London College of Medicine, instituted to meet the wants of the rank and file of the medical profession who were sorely oppressed by the presence of quacks within their body and by the competition of quacks without, contained the germ of the first Medical Act, while it made the medical profession consider how necessary a central governing body must be to regularise the proceedings of medical education. The possibility of Parliamentary interference began to be apparent to all, Members of Parliament in various constituencies were asked to familiarise themselves with the idea, and in 1839 a Bill was introduced by Mr. Warburton which nearly succeeded in passing the House, and which provided for the registration of medical practitioners. At this juncture Richard Carmichael, President for the third time of the Royal College of Surgeons in Ireland, and one of the most practical medical reformers of the day, wrote to Sir Robert Peel urging the necessity of registration, and pointing out that uniformity of examination was also required, so that the public might feel certain that by whatever portal a man entered the medical profession he could not obtain ingress without a certain equipment. Sir Robert Peel became interested in not allowing a great

measure of domestic reform to be shelved, and in 1840 a Bill providing for the registration of medical men was introduced by Warburton and Wakley, then a Member of Parliament. But the measure met with no success. It contained a suggestion that registered practitioners should take out an annual licence—a clause which was ill-received by medical men, although, as we know now, the merits of this reform were at least as obvious as its defects. In 1847 Wakley again obtained leave to bring in a measure entitled “A Bill for the Registration of Qualified Medical Practitioners and for Amending the Law relating to the Practice of Medicine in Great Britain and Ireland.” This Bill, though it never became law, led to the appointment of a select committee of sound, shrewd, important men, whose deliberations resulted, though not immediately, in the Medical Act of 1858. Macaulay was the first chairman of the committee, and representative members of all the qualifying bodies were examined at great length, with the result that in 1849 Mr. Rutherfurd, the Lord Advocate of Scotland, stated in the House that a measure providing for the registration of qualified practitioners in medicine would be laid on the table in a few days. It was found, however, that the various medical corporations and university medical faculties, from different motives of self-interest, could not agree to support the Bill. One wanted one thing and one wanted another, and in face of the manifold opposition all attempt at legislation was again dropped. This want of ability in those for whom the work was being mainly done to combine for the common good was

very mortifying to the medical reformers, and ten years elapsed before another serious attempt was made to pass a measure which all now admitted was wanted in the public behalf. In 1856, however, the Royal Colleges of England, Ireland, and Scotland, and the Medical Faculty of Glasgow had a conference of representatives, with the result that these important corporations came to an agreement as to their requirements. This appearance of unanimity led to early results, for in 1858 Mr. William Cowper introduced and secured the passage of the first Medical Act, the Act which, with its various amending measures, controls the medical profession at this day.

The Act, which is entitled "An Act to Regulate the Qualifications of Practitioners in Medicine and Surgery," states in the first clause, as the reason for its existence, that "it is expedient that persons requiring medical aid should be enabled to distinguish qualified from unqualified practitioners." The measure was clearly designed to protect the public, any benefit that might accrue from it to the medical profession being of secondary importance. The General Medical Council was called into being by the Act, which settled that certain universities and bodies should be entitled to grant medical qualifications, and that representatives of those bodies, together with six nominees of the Crown, should form a central authority for the education of the medical student and for maintaining the official roll of the profession. The constitution of the Council has since been altered in two respects, notably by an amending Act in 1886. Additions have been

made to the number of recognised qualifying institutions by the inclusion of the various new universities, while the members of the medical profession have been allowed to elect five of their number as direct representatives, three for England and one each for Scotland and Ireland. The principle of direct representation was granted upon the supposition that men would be chosen to sit upon the Council who were more familiar with the circumstances of medical practice than the representatives of the examining bodies would be; and in the opinion of some an increase in their number would liberalise the views and strengthen the deliberations of the Council. The duties of the General Medical Council and the scope of its work are but little realised by the public. The Council is authorised to keep a medical register, intended to enable the public to distinguish qualified from unqualified practitioners, and containing the names of all persons who are legally qualified medical practitioners and who, by virtue of their registration, are entitled to recover their professional charges in a court of law, to give valid medical certificates, to appear as medical witnesses, and to hold various offices or appointments. The Council cannot prevent the public inviting medical aid from persons not on the Register, nor can the Council take any proceedings against such persons so long as they do not infringe the Act by pretending to be on the Register. The Council keeps the official roll of the profession, but has no discretion with regard to registration. The Registrar of the Council is bound to insert the name of all applicants who are provided with the degrees,

diplomas, or licences specified in the Medical Acts, in other words, anyone who passes the statutory examinations can claim to be placed on the roll. The Council is authorised to remove from the Register, and thus to deprive of the above-mentioned legal privileges as practitioners, any persons who are convicted of crime or misdemeanour, or who may be adjudged by the Council itself, after due inquiry, to have been guilty of "infamous conduct in any professional respect." The clause of the Act under which its penal powers are exercised runs:—

"If any registered medical practitioners shall be convicted in England or Ireland of any felony or misdemeanour or in Scotland of any crime or offence or shall after due inquiry be judged by the General Council to have been guilty of infamous conduct in any professional respect, the General Council may, if they see fit, direct the Registrar to erase the name of such medical practitioners from the Register."

It will be seen that there is no attempt at defining what constitutes "infamous conduct in a professional respect," and one of the most delicate and responsible of the Council's duties is to decide upon the justice of removing offending persons from the Medical Register. In respect of its correctional duties the Council is authorised to require from any of the licensing bodies information with regard to the courses of study and examinations to be gone through in order to obtain their respective registrable qualifications, and to visit and inspect the examinations. In the event of the Council considering the courses of study or the examinations insufficient to guarantee the possession by the persons obtaining

the qualifications of due knowledge and skill for the efficient practice of their profession, the Council can represent the fact to the Privy Council, the department of State to which it owes allegiance. The Privy Council can take such action as may be necessary. To the General Medical Council, also, is given the duty of preparing and publishing the British Pharmacopœia, the official list of medicinal remedies with their doses. The sale of this publication forms the Council's revenue in addition to the registration fee of £5 from every practitioner.

The powers of the Council as the controlling medium of the conduct of medical practitioners are elastic, but the reason of the phraseology of the Act becomes apparent when we remember that the Council exists for the protection of the public and not for the protection of the medical profession. The legislature evidently contemplated the possibility of conduct on the part of a medical practitioner which, while it might be insufficient to bring him within the grasp of the criminal law, would be amply sufficient to show his unfitness to be trusted with professional opportunities and responsibilities. The Council is entrusted with the duty of deciding upon the professional behaviour of a medical man, and is empowered to erase the name of anyone from the Register who does not behave in a manner befitting his delicate position towards the public. But the effect of removing a medical man from the Register is, of course, to deprive him absolutely of any legalised medical status and of any power of legally earning his living as a medical practitioner. In the case of the criminal this is not of great matter, for it is

difficult to conceive any circumstances in which the medical profession and the public alike would not be benefited by the removal of a convict from the official roll, but in the case of the man whose offence is rather a proof of bad taste or bad form than of wickedness, the Council shrinks from taking the extreme step of erasure in any but gross instances. This was particularly true when erasure from the Register was permanent, as it was at first. Then the terrible nature of the punishment would now and again lead the Council to err on the side of leniency, but an ingenious procedure, suggested to the Council by its solicitors, gave power of restoration to the Register, so that the punishment of an offender can now be made more nearly to fit the crime.

Such, briefly, are the powers and duties of the General Medical Council, and for practical purposes to understand what the Council can do and cannot do is to understand the position of the medical practitioner under the Medical Acts, and to appreciate his duties towards the public. In describing the state of the medical profession in England, Scotland, and Ireland in the subsequent chapters, the various obstacles that beset the path of the practitioner will be detailed. It will be found frequently that although his grievance may be acute the Council is unable to help him, owing to the limitations of its powers, and to the very definite object of its creation—viz., the public weal. But this is not at all generally understood. We often see questions like the following asked:—"Why does not the General Medical Council put down quackery?" and "Why does not the General Medical Council prevent the holder of a

bogus American degree from practising?" The Council does not do these things because it has not the legal power. The Council can only interfere when the quack pretends to be a properly registered person. Then, under the clause of the Act which says that the Register is to be compiled for the instruction of the public, so that the public may be able to discriminate between the properly qualified medical man and the quack, the Council can take legal proceedings. It must be clearly stated that the Council, as at present constituted, cannot defend either the public or the medical profession in the way that it is often invited to do. The remedy for this ineffectiveness is amendment of the Acts.

CHAPTER II

THE STATISTICS OF THE MEDICAL PROFESSION AND THE CHANCES OF SUCCESS

The Ratio of Medical Men to Population.—The Figures in Austria-Hungary, France, and Germany.—The Average of Success.—Sir James Paget's Investigation.—A Supplementary Investigation.—The Fallacy of Figures.

THE numerical ratio of employed to employer is one of the first things to look at in an attempt to estimate the material or financial position of the members of any section of the community. There is particular reason to do this in respect of the medical profession, because many of the drawbacks to the professional life of the medical man, as well as many of the circumstances wherein medical endeavour seems not to meet the public need, are attributed to the downgrade tendencies of competition. Of course the services—the depreciated services—of an overcrowded profession will be obtained more cheaply by the public, but it will not do to assume without inquiry that the medical profession is overcrowded, if only because a general excuse for many and particular ills should never be accepted without rigorous test. If it once becomes a matter of assumption that low remuneration must be received, and that humiliating contracts must be entered into

because of the demoralising influence of overcrowding, the desire to remedy abuses will be killed by a fatalistic tendency to put up with a condition of things which is supposed to be due to some unalterable law of supply and demand. The figures do not bear out the statement so frequently made that the profession of medicine in the United Kingdom is grossly overcrowded.

The first of the tables which follow gives a numerical analysis of the members of the medical profession, taken from back numbers of the *Medical Directory*. I have given the figures for the last six years consecutively, and have then added those for 1861, 1871, 1881, and 1891, so that the respective figures in these columns may be compared with the population of the United Kingdom, according to the decennial census for those years.

The second table gives the population of England (including Wales), Ireland, Scotland, and the Islands for the years 1861, 1871, 1881, 1891, and 1901.

Taking as a guide the decennial increase of England and Scotland and the decennial decrease of Ireland it is probable that for the present purposes 42,750,000 represents sufficiently nearly the population of Great Britain and Ireland. We therefore see that in 1861 there was one registered medical man to 1,271 inhabitants; in 1871 there was one medical man to 1,370 inhabitants; in 1881 there was one medical man to 1,558 inhabitants—the population having taken an upward leap; in 1891 there was one medical man to 1,283 inhabitants; in 1901 there was one medical man to 1,144 inhabitants; and in 1904 there was one medical man to 1,133 inhabitants.

TABLE I.¹

Year.	1861.	1871.	1881.	1891.	1899.	1900.	1901.	1902.	1903.	1904.
London list	—	—	3,994	5,095	6,117	6,102	6,211	6,292	6,309	6,328
Provincial list, England	18,642*	18,884*	11,319	13,926	15,497	15,794	16,095	16,232	16,422	16,553
List for Wales	—	—	†	†	1,100	1,127	1,165	1,183	1,186	1,207
List for Scotland	1,870	1,780	2,003	2,739	3,394	3,462	3,569	3,645	3,680	3,696
List for Ireland	2,357	2,420	2,416	2,489	2,551	2,559	2,575	2,587	2,641	2,629
Registered practitioners resident abroad	§	§	2,252	2,795	3,795	3,875	3,910	3,952	4,117	4,292
Naval, Military, and Indian Medical Services	§	§	2,445	2,440	2,528	2,705	2,798	2,886	2,917	3,016
Too late list additional names ...	§	§	43	40	12	27	31	11	19	9
Total	22,869	23,084	24,472	29,524	34,994 (increase 91)	35,651 (increase 534)	36,354 (increase 703)	36,788 (increase 434)	37,291 (increase 503)	37,730 (increase 439)

* The figures for England and Wales are given *en bloc*.
† The *Medical Directory* gave no separate figures for Wales in these years.
§ Details not forthcoming.

TABLE II.¹

Years.	England.	Ireland.	Scotland.	Islands.	Total.
1861	20,066,224	5,798,967	3,062,294	143,447	29,070,932
1871	22,712,266	5,412,377	3,360,018	144,638	31,629,299
1881	25,974,439	5,174,836	3,735,573	141,260	35,026,108
1891	29,002,525	4,704,750	4,025,647	147,842	37,880,764
1901	32,527,843	4,458,775	4,472,103	150,370	41,609,091

¹ The proprietors of the *Medical Directory*, Messrs. J. & A. Churchill, kindly furnished the information for compiling these tables.

These figures must further be corrected to the advantage of the medical man by subtracting the registered practitioners resident abroad and a certain number of the medical men holding commissions in the Navy, the Army, and the Indian Army. By making these necessary allowances it becomes clear that the ratio of medical men to the public to-day is really much the same as it was in 1861 or 1871. May it not be taken for granted that a numerical ratio which has held good, with but one considerable variation, for forty years or more, has something inherently right about it?

That the members of the medical profession in England (including Wales), Scotland, and Ireland are divided in such a way as to create a plethora in one place and a dearth in another is a different matter altogether, though here we are at no disadvantage compared with other countries.¹ In Austria-Hungary, for example, where 18,000 medical men minister to the needs of 47,000,000 people, it will be seen that the ratio of medical men to population is only half that which obtains in Great Britain and Ireland. But, as a matter of fact, there are many districts in the provinces of the dual empire with no medical men at all, all the practitioners being crowded into the cities and watering places. The 18,000 medical men do not serve a population of more than 25,000,000 or so, and the real proportion

¹ An admirable special number of the *British Medical Journal*, published on June 3, 1905, and dealing with the medical profession abroad in its educational, social, and economic aspects, gives the statistics of the medical profession in some of the European countries very fully.

does not differ much from that found among ourselves. In France the figures are a little different, the same number of medical men approximately (18,871) having the care of a population of 39,000,000. But in France also there are vast tracts of country where medical men are very few, though homogeneity of race and language prevents the complete isolation of districts which prevails in Austria-Hungary. In Germany there appears to be one medical man to 1,934 of the population, the great towns being especially over-provided with physicians and surgeons. In Berlin the proportion of practitioners to population is 1 to 766, in Munich it is 1 to 608. But in some of the outlying provinces there are no medical men at all. Take the province of Gumbinnen, for instance, a district in Eastern Prussia near the Russian frontier. Here the proportion of medical men to population is 1 in 4,100. It is such inequalities in distribution that produce the problem of overcrowding in certain places, and in England and Scotland and Ireland these inequalities are less marked than in Germany, France, and Austria. Of course our capital towns, our best-known watering places, and the sites of our medical schools attract many as family practitioners, as consultants, or as teachers, but the general social and geographical conditions with us conduce to a more or less even distribution of medical service. The contention that the serious overcrowding of the medical profession makes it impossible to remove many of the grievances which are certainly present in the medical life, and which curtail the public utility of the medical profession, cannot be sustained. Here and

there the stress of competition tells, and tells forcibly, but on the whole it has been exaggerated.

In 1869 Sir James Paget undertook, with the assistance of a colleague at St. Bartholomew's Hospital, an investigation into the chances of the medical student as shown by his subsequent career. The investigation resulted in the publication of figures showing that a medical student had at least as good a chance of worldly success as a lad embarking in any other career. Sir James Paget followed up the lives of a thousand medical students who had joined the medical school of St. Bartholomew's Hospital with the following result¹:—23 met with distinguished success, 66 met with considerable success, 507 met with fair success, 124 met with very limited success, 56 failed, 96 discontinued medical studies while in pupillage, 41 died during pupillage, and 87 died young.

Sir James Paget defined "distinguished success" as the attainment within fifteen years of qualification to a leading position in practice in great cities, to a scientific professorship at a university, to a place on the staff of a large hospital, or to the tenure of some important public office. He ascribed "considerable success" to those who gained high positions in the Services, obtained good provincial and country practices, and enjoyed more than ordinary esteem and influence in society. "Fair success" he defined as being in the possession of a practice sufficiently

¹ *St. Bartholomew's Hospital Reports*, vol. v., 1869. A very interesting volume recently published, *Doctors and their Work*, by Mr. R. Brudenell Carter, contains some suggestive comments upon these figures, which are also dealt with by Mr. Charles Booth in *Life and Labour of the People in London*, in the volume classifying the population by trades.

large to maintain a professional man in adequate style, or the tenure of an advancing position in the Naval, Military, Indian, or Colonial services. "Very limited success" he assigned to those who never attained to moderately good practice, but who were able just to maintain themselves by their work either as principals or as assistants. Of the 56 who failed 15 could not pass their examinations, 5 were convicted of misconduct, 10 were dissipated both as students and afterwards, and 10 had bad health. The remainder were known to have come to grief without any particular reason being assigned for their misfortune. It will be seen that out of the thousand students 41 died during pupilage and must be left out of count. Again, the 96 who discontinued their medical studies while in pupilage can hardly be brought into calculation when we are considering the chances of making a livelihood out of the practice of medicine. They cannot be said to have failed in a medical career as they never attained to professional rank. The fact that nearly 10 per cent. of the thousand students left the profession during their studies is not without significance, as it would seem to imply that the medical profession was not one to be undertaken lightly, even in days when examinations were comparatively simple and infrequent, but this is a different matter altogether. A parent when sending his son into the medical profession ought to know that there is a chance of that son never obtaining any qualifications. But this should not be mixed up in his mind with apprehensions as to the future, after qualifications have been obtained. The 41 who died during pupilage, and the 87 who died before they had

been in practice twelve years were also debarred by sad fate from obtaining any position in their profession, and they can be left out of calculation for practical purposes. We have, then, 776 students to consider who actually reached practice, and of these 507, or about 66 per cent., attained to fair success. These are the figures that we must look at when we try to frame our opinion as to the chances that a boy has of becoming a useful, happy, and responsible citizen if he elects a medical career.

The figures that signify success above the average or total want of it are not without their lessons, the number and magnitude of the prizes to be attained being an inducement to join the profession, exactly as the risks of failing utterly at the beginning form drawbacks to a start in the race. The early wastage is a matter of grave importance both to parents and to aspirants to the medical profession, and there is every reason to believe that it has increased of late owing to the multiplicity of examinations. Again, the dearth of lucrative appointments and the comparatively small pecuniary gains that accompany distinguished success are matters that must not be disregarded. The successful medical man may attain to a high position and a large fortune, but he does so very rarely, and many men who conform to Sir James Paget's definition of distinguished success live and die without popular favour, their names being unknown to the majority of their fellows, their incomes being small, and their public influence negligible. It stands to reason that a profession where so many of the prizes resemble blanks will not be selected, either for themselves or for their children, by those who have a

keen eye to the material opportunities of life. But if the young medical man sees no high position within his possible grasp comparable to that of the judge or the bishop, if he has not the golden expectations of the man of affairs, still he may have visions of scientific fame, altruistic dreams of serving his generation, and generations to come, immortally well, and such a man would not exchange his hopes for the chances held out by other callings. And although the money rewards in the medical profession are small, while the public offices filled by medical men do not appear important to those ambitious for popular authority, the very significant fact appears from Sir James Paget's figures that 66 per cent. of medical men make a fair success in England, Scotland, and Ireland out of the practice of their profession. This seems at once to place the medical profession in the United Kingdom quite high as a stable means of livelihood. The barrister, the clergyman, the architect, and nowadays the solicitor cannot claim the same for their callings. If an investigation on the lines suggested by Sir James Paget were undertaken into the careers of a thousand divinity or law students, no such high average of comparative success would be shown.

As, however, nearly a working lifetime has elapsed since Sir James Paget's research into the careers of a group of his numerous pupils at St. Bartholomew's Hospital was made, it might be thought that with the lapse of time and the alteration of conditions the figures would no longer hold good. Bearing this in mind, permission was obtained from the dean of one of the best-known English hospitals to make a brief

investigation into the careers of a group of students who had been entered for education at the medical school of that hospital.

The year 1879 was chosen, and what happened to the first 250 students who entered after October 1st at that institution was ascertained superficially. The date was selected because the investigator joined the school a little later and was able, from personal knowledge, to remember facts and circumstances in the lives of a large proportion of the men under consideration, some having been his teachers and some his comrades, while, where personal acquaintance failed, it was easy to find a friend who could supply the gaps in the information. Of the 250 students 187 qualified and 63 did not qualify. Of the 63 who did not qualify as medical men two obtained places in the dental register without diplomas, and are doing well, and two died as students; one is decently successful at the bar, one became a veterinary surgeon and enjoys a high reputation in that profession, one accepted a purely scientific post under Government and is steadily rising in his department, one became an artist, three went on to the stage with no success, two enlisted in the army and both obtained commissions, and one became proprietor of a boarding-house. Four of them who gave up the struggle were men of private means, to whom the practice of a profession was not necessary as a livelihood. Of the remaining 45, 15 of them never showed the least aptitude for medicine, and among these were five or six lads who lived mainly for the sensual pleasures of life in a great city.

Of the 187 students who qualified nine may be

said to have met with distinguished success as defined by Sir James Paget, five of them secured, after more or less waiting, positions on the medical or surgical staff of their own hospital, and two became teachers at the hospital; two others are on the staff of large general hospitals in the provinces; 45 have met with considerable success in practice, they hold good appointments, have earned a strong local position, and are respected prosperous citizens; 25 hold commissions in the Services, 19 in the army and six in the navy; of these, two have distinguished themselves and have been decorated, one having become head of an important department. Of 56 men in general practice in England, including five who practise dentistry, it has been learnt that they are living by medical practice in a manner compatible with a professional position; out of nine who are abroad two have been distinctly successful. Five men who obtained qualifications left the medical profession, of whom one is a journalist, one is an actor, one has also been on the stage, and two are men of private means; only six men came distinctly to grief, of whom two went to prison; 23 men died before they had been qualified twelve years, and must be disregarded in making any estimate as to the chance of success by the practice of medicine. Of the rest, about 12 per cent. of the total, it was not possible to learn anything, though their position on the Medical Register would imply that they are still in practice.

The following are the figures which can be compared with Sir James Paget's figures:—Nine have met with distinguished success; 45 have met with considerable

success ; 25 have met with fair success in the Services (two of these might be included in a higher class) ; 46 have also met with fair success in practice ; 5 left the profession after qualification ; 6 discontinued medical study as pupils ; 2 died during pupilage ; 23 died within twelve years of commencing practice ; and 6 failed entirely. Liberality has been shown in awarding places in the higher classes, but if we add the "considerable" and "fair" successes together we get by the combination a section of 116 men out of 187. That is to say that the figures, like Sir James Paget's figures, though with much less certainty, because of their incompleteness and the smaller range of the investigation, go to show that 66 per cent. of qualified medical men from one metropolitan medical school have reason to be satisfied with their professional careers.

Too much stress must not be laid upon the meaning of any of the foregoing figures. That figures, particularly if large deductions are attempted from small data, can be made to prove most things is illustrated in many controversies, and it is safer to claim proof for as little as possible through their agency. But the figures can fairly be used as replies to two vague but common assertions : (1) that the medical profession is overcrowded ; and (2) that in following the medical life the game is not worth the candle. These two statements have been made so often that they are beginning to receive unquestioned acceptance. As a matter of fact, the medical profession in England, Scotland, and Ireland is not overcrowded so much as badly distributed. There are places where medical men are sorely needed and

where they would be found if the conditions were fair; there are large districts where medical work is waiting to be done until proper arrangements have been made by the State for doing it. When the administration of the poor-law and the sanitary service in the three countries is considered, as well as the warrants of the naval and military Services, it will be seen that certain necessary measures of reform would at once create a demand for medical officers. The employment is ready, but as yet no proper provision exists for the employed. This is not the same thing as saying that the medical profession is overcrowded.

Again, the percentage of medical men who attain a good and stable position through professional practice disproves the view that the medical profession as a whole is wrongly paid. But the figures must not be taken to show that there are no grave professional hardships. In both cases they refer to students at first-class London hospitals, students of the class who enter the profession with fine introductions and whose natural sphere of practice presents the maximum of opportunities. It would be possible by selecting students of other schools to obtain somewhat different results, though not results that would contradict the general inference that by comparison with many other callings the medical profession promises much.

CHAPTER III

THE CONSULTING PHYSICIAN AND SURGEON

The Chances of the Medical Life.—The Position of the Consulting Physician and Surgeon.—The Growth of Specialism.—The Birmingham Consultative Institution.

A SURVEY of the medical profession at once reveals the varied opportunities that the medical life holds out to men of different bents of mind. The consulting physician, the operating surgeon, the general practitioner, the holder of purely scientific appointments, the holder of sanitary and municipal appointments, the medical officer in the navy, in the army, in the Indian army, and in the colonial service—the careers of all these differ entirely. For some life will be essentially adventurous; for others it will be spent in two or three wards, an operating theatre, and a consulting room. Some will be the trusted friends of the great and the wise, so that the most exclusive doors will be open to them; others will serve under authorities and municipalities composed of men whose education and position are not equal to their own. And some must live the life of the poor with the poor. The sportsman can indulge his proclivities in moderation while discharging his professional duties with zeal, and small will be his chances of success if he interchanges the zeal and

the moderation. The man who loves the study of his fellows has social and psychological problems unrolled before him from hour to hour—he sees naked souls as well as naked bodies, and has to take the treatment of both into his consideration; while he whose sympathies are rather with the theory than with the practice of his art can exert his energies in the class room or laboratory without coming into collision with the public. All sorts of persons in all sorts of methods and under all sorts of skies can carry on the profession of medicine, so that there need not be many to whom the medical life is irksome. There will be an unfortunate few, who, being by nature designed for work of one kind, have by stress of circumstances been forced into a different groove. Probably they did not discover their own tastes until it was too late to work in the necessary direction, and this error is a very difficult one to rectify, whatever calling in life a man may adopt. But, speaking generally, the profession of medicine has this first advantage for its British disciples—an advantage which citizens of smaller empires do not enjoy—it offers a career that can be varied to suit all tastes. A high percentage of the followers of medicine attain to a fair degree of success, the total failures are comparatively infrequent, and no man need follow a thoroughly uncongenial employment as a medical man because of the great diversity of careers that is open to him. These three things must always be remembered, for while many circumstances may be held to detract from the medical life, these three things, whatever those circumstances, establish it as a good life, offering chances to a man with brains and energies to take

advantage of them—chances of choosing a proper sphere of labour and of remaining to some extent master of his own career, even while obeying the conventions and the restrictions entailed by modern civilisation.

But none the less the grievances of the medical profession are very real, as are the various circumstances which militate against the progress of medicine, and which, by depressing the scientific, material, and social status of the practitioner, make him a less useful instrument for the safeguarding of the public. That these grievances are of many kinds is assured by the fact that there are many kinds of medical practice. And if some of them seem common to all sections of medical practice while others seem peculiar to one section or another, it must be remembered that the subdivisions are subdivisions of practice only ; the broad aims of every member of the medical profession are the same, his ideals are the same, and his responsibilities to the public are the same ; and whatever interferes with the due development of the utility of one branch of the profession affects the whole professional body, and reacts detrimentally upon the public. We shall now consider the position of the consulting physician and consulting surgeon, who are typical of professional success and the value of whose work is recognised cordially by all classes. Here there are no serious revilings against fate on the part of the medical men, for consultants are exempt from most of the ills that wait upon general practitioners. Cheap contract practice does not affect them, their patients do not desert them in bulk for the gratuitous treatment of hospitals, they make no

bad debts, and the competition of quackery does not bear hardly upon them.

The consulting physician and the consulting surgeon represent the fine flower of success in the medical profession. They are the class in Sir James Paget's classification for whom the designation of "very distinguished success" is reserved, and, as has been implied, no time need be occupied in detailing their chances of ill-success, which are largely comparative and are expressed by saying that times have altered much of late and that competition has become severer. When the class from which hospital physicians were drawn was a very small one, and when the "pure" surgeon was followed in his appointment and practice by favoured pupils, the lack of rivalry among the consulting class was conspicuous. It was ensured by an early line of demarcation being drawn between those who might and those who might not hope to attain to leadership in the medical profession, and we do not suppose that there exists anyone sufficiently illiberal to regret the ancient order. But with the multiplication of universities, the growth of provincial medical schools, and the complete abolition of direct and indirect traffic in hospital appointments, there has come a marked increase in the number of candidates for the highest professional honours. Round every general hospital to which a medical school is attached a band of young men await the opening for which they have fully equipped themselves. But to obtain their hope does not necessarily mean success. For those who gain staff appointments or hospital appointments soon find that the struggle upon which

they have embarked is a severe one, and that the trials of competition are not over because they have succeeded in getting on the bottom rung of the ladder that leads up to distinguished success. There are so many others in the same position, and the number continues to grow as the number of hospital appointments, whether at general or special hospitals, grows. The young general consulting physician, in England, Scotland or Ireland alike, finds it very hard, as a rule, to earn enough money to live until the public are aware of his existence, while the teaching appointments upon which he would have relied in days gone by are at many of the best centres of medical education no longer lucrative. If the plight of the young consulting surgeon is better, because in the matter of operations the public is not so loth to trust a young man as where "pure" medicine is concerned, still he also feels the strain of competition and the loss of emolument for his educational labours. When the science of medicine was much simpler, and when the education of the medical student was a much less costly thing, the fees paid to a medical school were in excess of the cost to the school of supplying the student with the necessary facilities for education. The surplus was divided among such of the medical staff of the hospital as held teaching appointments. And although it is now some time since lectureships at many of the medical schools have been worth substantial sums, it is only in comparatively recent years that the position has been established that a large part of the education of the medical student has to be carried on by gratuitous effort. This is the case in London, which

ought to be the greatest medical centre of the United Kingdom, and the plight has been reached mainly on account of the great increase in the expense to the medical schools that results from the developments of physiology and bacteriology. Expensive practical courses have to be arranged, expensive laboratories have been built, and the result is that medical schools cannot pay their lecturers adequately, and may even have to draw on the funds of their hospitals to keep afloat.

The loss of valuable income obtained by tuition during the critical early time of professional life falls now upon the consultant when he has to bear the strain of a new and increasing class of competition—the competition of the special hospitals. The growth of special hospitals has created a large increase in consultants of the specialist type, and the public believe implicitly that the medical man ought to be a specialist. There is some reason in the view, just as there are powerful arguments against it. The evolutionary processes of medicine and surgery, and the opportunities for interchange of knowledge afforded by the multiplication of medical societies and medical journals, have made it impossible for any medical man to keep level with the ramifications of his science in special directions, and as a consequence it is now quite usual for a consultant to make choice of a line along which he proposes to work. If he is at a general hospital he becomes associated in the minds of his colleagues and of his pupils with cases of a certain sort, the wards of his hospital give him scope for clinical research, and its records enable him to interpret the lessons of the past by the knowledge

of the present. If he is at a special hospital, though he has not the same opportunity of keeping in his memory the general rules by which special problems must often be solved, still he has probably more valuable material—material which more immediately and more frequently illustrates the recurring difficulties of treatment. All this implies that along any groove of medicine competition among the consulting authorities is more than doubled. Again, there are special hospitals which foster hospital abuse by having no adequate regulations to prevent the well-to-do public from obtaining advice at their outpatient departments in return for small sums of money. These institutions undoubtedly deprive the consulting physicians and surgeons of much professional work for which they should receive remuneration, though the public is not always to blame, for in many such cases the evil has arisen through the direct action of medical men. Hospital abuse is a subject to which further reference will be made in discussing the position of the general practitioner; but it is well to point out here that it weighs sometimes as heavily against the consultant as against the general practitioner, for this aspect of the matter is frequently missed.

Through competition, fair and unfair, and through the spendthrift policy entailed upon the medical schools by the educational conditions of to-day, the consulting physician and the consulting surgeon at the beginning of their careers have often a severe struggle. Yet when we have said this, the fact remains that they form the really successful members of their profession; and so far from succeeding to

that position by the favour of extrinsic circumstances, as would have been their lucky lot in days not long gone by, every step has to be won by competition. Every post is wrested from men apparently of equal merit, and hard on the heels of every holder of a post treads another ready to take his place. And the posts so striven for are practically unpaid ones, while the public, save in exceptional circumstances, is apt to be many years before it is prepared to remedy the pecuniary deficiency. Success is only won by incessant hard work, self-denial, and courage, for the number of cases of genuine and abiding success that follow upon irregular methods, such as self-advertisement, is small.

The public finds fault not infrequently with the fees of consultant physicians and surgeons, holding them too high, and the abuse of hospital treatment is frequently defended on this ground. A large section of the public asserts that it is driven to the hospitals because it is unable to pay the fees of the consultant physician, amounting to one guinea or two guineas, to say nothing of the heavy charges of the operating surgeon. There is much force in the contention. It is undoubtedly the case that the rich and the poor command the services of the most highly-paid medical men—the rich by their cheque books and the poor by their appeals to charity; while the great middle class is not able to obtain these services save by a dishonest masquerade of poverty or by the expenditure of money that cannot be spared.) This is a condition of things that will soon demand a remedy, and the remedy will be found by proper co-operation between the medical profession and the public. Hospitals

that receive paying patients, and nursing homes where patients can be received for operation are becoming fairly numerous, but there remains much about them that is unfair to the medical profession and much that is very irksome to the public. It is quite certain that the situation will soon be improved, but it is equally certain that satisfaction will only result from the joint deliberations of medical men and laymen, who are equally concerned in arriving at the just and practical course to be pursued.

It often appears extraordinary that in these and similar situations medical men and laymen do not lay their heads together, for much friction might in this way be avoided. Certain astute citizens of Birmingham, some six years ago, having awoke to the admitted fact that the fees for medical consultations press hardly upon a section of the community, decided to remedy the evil without reference to the medical profession at all. They started a "Consultative Medical and Surgical Institution" which purported, to quote an advertisement in a local paper, "to lessen the strain upon hospital charity by providing, on terms within and under conditions suitable to their pecuniary means and position, medical and surgical aid to those who would otherwise seek it gratuitously or be unduly taxed by paying the usual consultation fees." The objects were laudable, but the ludicrous manner in which it was attempted to carry them out foredoomed the scheme to failure. The services of genuine consulting surgeons and physicians were not to be requisitioned, but two so-called "consultants" were to be hired at £500 per

annum each, and their earnings, estimated at £3,000 per annum, were to be placed to the credit of the Institution. The projectors of the scheme, with the honest idea of doing good, succeeded only in setting on foot a double-edged swindle. The medical profession was to be exploited, and the public was to pay fees to two persons under the pretence that they were a consulting physician and a consulting surgeon of special knowledge, when it must be clear, from the terms offered and the conditions of employment, that they could only possess the usual standard of skill. As a matter of fact only one medical man was found willing to be run as a consultant upon such conditions, and his career was closed by the action of the General Medical Council, which found the circumstances of his employment undesirable. The Birmingham Consultative Medical and Surgical Institution failed because its projectors had not the least idea what a genuine consultant is, or what his duties are in the opinion of the medical profession as a whole. A consulting surgeon or a consulting physician is not made by an assumption of the title, he must have some claim to wide and special knowledge which would lead other members of the medical profession to seek his advice in difficult cases. He usually has the experience gained by hospital practice, and he looks not to the public but to his professional brethren for support. A number of the genuine consulting physicians and surgeons of Birmingham completed the discomfiture of the Birmingham Consultative Medical and Surgical Institution by offering to see, advise on, and prescribe for *suitable* cases at the fee of 10s. 6d.—the fee

which the Institution proposed to ask—if the suitability were guaranteed by a member of the medical profession. That is to say, that a patient whose symptoms were so obscure that the opinion of some medical man having particularly wide or special knowledge was required, and whose means made the fee of two guineas or one guinea prohibitive, could obtain consultation upon his case for half a guinea, if his medical adviser would put the facts before the consultant. And for his half-guinea he would get, not the opinion of a man holding no hospital appointment and enjoying the title of “consultant” through a patent conferred upon him for business purposes by two or three members of the public, but the opinion of a man selected out of a group who had all earned their style of “consultant” by their proved scientific work and by the educated support of their professional brethren. If the Birmingham Consultative Medical and Surgical Institution had invited the co-operation of medical men, instead of being openly in opposition to them, these things could have been made clear from the beginning, and possibly Birmingham might have seen the first legitimate and practical attempt to deal with a difficult problem. As it was the scheme was bound to fail, for the Institution proposed to sell what it could not buy.

CHAPTER IV

THE GENERAL PRACTITIONER AND CONTRACT PRACTICE

The Grievances of the General Practitioner.—Medical Aid Associations.—The Battle of the Clubs.

THERE is no intention to portray the life of the general practitioner as one long series of hardships, one monotonous record of ill-requited labour, because the grievances which he endures are the points now to be dwelt upon. To take this melancholy line would be to pay no attention whatever to the figures which have been given already, and which indicate that in a material sense the profession of medicine in the United Kingdom compares well with the other professions. It would also be to ignore the high sense of responsibility and keen pleasure of saving life or relieving pain which give to a medical career its chief charms. But none the less the grievances of the general practitioner are very substantial; the measure of the hardships which surround and impede his life has never been realised properly either by the public or by the medical profession as a whole. This want of appreciation by the public of the troubles affecting those who live more than any other section of the community by the alleviation of the troubles of others has been brought about in an

obvious manner. Medical men have rarely made a common cause against abuses which threaten or assail them, and those who have done so have acted generally in a half-hearted manner, feeling that they were without the material or moral support of their natural leaders, the great figureheads of medicine, and sore at being termed trade-unionists. The public is not conspicuously in agreement with the aims of medicine and has not the trust in its medical advisers that it manifested a generation ago. The public is educated to the point of scepticism as to what it cannot understand, but no further; and a certain section of the press, having no exact information upon medical matters, makes statements which go far to foster misunderstandings. It is not to be regretted that the public has lost blind faith, but it is unfortunate that there has not been acquired, with a wider mental horizon, a more reasonable grounding in scientific facts. The general practitioner has to meet his adverse circumstances with a proportion of the public ready to regard him distrustfully, with no effective methods of combination, and without influential leadership. The grievances under which he suffers to which special allusion is now to be made—namely, the evils of contract practice, the prevalence of hospital abuse, and the grave growth of quackery—are of a material kind. Primarily, that is to say, they affect the purse of the medical man and his status in society. The first two of these are the things that directly or indirectly cause the general practitioner to be underpaid; and from them the situation arises that either he puts up with imposition, which gives him a constant sense of

soreness and never wins him the least appreciation from the public, or he resists it, in which case he is made to appear a grasping and extortionate person. Also he soon discovers that in the majority of cases he is quite unable, through lack of combination with his fellows, to gain anything substantial by resistance.

Although the overcrowding of the medical profession in the United Kingdom has been much insisted upon for insufficient reasons, it is true that in certain places competition becomes too acute with an inevitable cheapening of medical service. Undoubtedly there are too many young medical men in England who desire to start in independent practice, preferably in a town, immediately they have placed their names on the Medical Register. They are not willing to act as assistants; the various services have no great attraction for them; and being without capital they are ready, even compelled, to take the first opening that offers. In this section of the medical profession there is overcrowding, and advantage has been taken of the fact, as was inevitable. The public, through so-called medical aid associations, has attempted by means of strong organisations to obtain mastery over medical service without realising how disastrous to all concerned such a movement must be. It is about ten or twelve years since certain members of the medical profession, mostly in possession of middle-class practices in large towns, began to be aware of the danger that was threatening them through such bodies as the Manchester Unity of Oddfellows, the Foresters, the Druids, the Temperance Society of the Rechabites, the Industrial

Assurance Company (Limited), the National Medical Aid Society, and many local associations. Complaints were made now from this town and now from that, and some persons well versed in medical politics knew that serious general trouble was arising. Local medical societies and branch meetings of the British Medical Association were addressed by aggrieved members and a few out-spoken letters made their appearance in the press. But for the most part the injured parties contented themselves with grumbling; but little attempt was made to diagnose the exact condition and to treat the cause, and no leader arose to formulate any policy of defence or reprisal. The medical profession as a whole hardly realised the extent to which it was being exploited until "The Battle of the Clubs" (as the struggle has been called) was started at Cork. The issues at Cork were exceedingly simple. The medical men of the city found that their private practices were falling off, and those of them who were medical officers to clubs had no difficulty in appreciating the reason. An undue proportion of substantial citizens, large tradesmen, employers of labour, and salaried clerks were joining the medical clubs and were demanding to be treated on the same terms as artisans and labourers, and even seeking that a small yearly fee should cover attendance upon every member of the subscriber's family. The medical officers to the clubs protested. They required that persons in a proper position to pay fees for medical aid should pay them and should not accept unwilling charity at the hands of medical men, often in poorer circumstances than themselves. The clubs paid no attention to the

protests, and the medical men resigned their appointments and formed themselves into an association having the defence of their professional position as a common object. They refused to work again for the clubs save at enhanced rates and with proper opportunities of deciding who were and who were not fitting objects for medical charity. The clubs imported persons as medical officers, whom the Cork medical men refused to meet as professional brethren. The imported practitioners made little headway in the city, the patients in large quantities deserted the clubs and returned upon fair terms to their original medical advisers—in short the medical men of Cork won the day.

At this juncture *The Lancet* despatched a special commissioner to various medical centres in the kingdom, who made reports of great interest and convincing frankness.¹ He showed in how many ways the evils of contract practice had grown up. Those medical men who already knew from personal experience something of the matter were reinforced in their sense of the reality of their grievances by finding them shared with so many of their professional brethren, while medical men into whose ken such matters had never entered became acquainted with the troubles of a large section of their colleagues, and so were prepared with valuable sympathy.

Some of these societies have as their primary object schemes for life assurance only adding their project for medical aid as an inducement to the public to enter their fold. They form an example of

¹ *The Battle of the Clubs*, by the Special Commissioner of *The Lancet*.

the way in which a bad influence may spread, for certain life assurance offices, not over careful in their methods, having commenced touting for custom among the poor in this fashion, other and better offices have declared themselves compelled to follow suit. Some of the schemes to secure for the public medical attendance at low rates—a very worthy programme if it can be carried through without the oppression of other people—are devised, as far as the medical officer is concerned, with cynical callousness. The medical officer's salary is small, his work immense, and the conditions under which it has to be done preclude him from exercising his calling scientifically. Some of the associations are well managed in that an effective attempt is made to insure that only the truly necessitous shall be the recipients of medical charity. Some are uncommonly ill-managed in that all persons, no matter what their condition of health or their means, are invited to enrol themselves that they may be treated medically for 1*d.* a week, drugs included. In certain of these institutions, the management of the association having been, and remaining, entirely in lay hands, the interests of the medical officers suffer particularly severely. The patients who might reasonably have been expected to pay them as private clients are not ashamed to join the charitable associations—charitable to all save the medical men—and often want to have their wives, children, immediate relations, and occasionally the stranger within their gates treated in return for one payment. Many a medical man has found his private practice drifting into the hands of these bodies. The associations take his humbler

patients from him, and place this issue before him—will he attend *their* members in *their* way at *their* time under *their* rules for *their* fees, or will he have a salaried rival brought in against him? Some medical men have surrendered; others, particularly where there was a chance of combination against oppression, have held out. Where the middle-class patients, pauperising themselves, listen to the blandishments of the agents of the association, and join the clubs in spite of their ability to pay their medical men proper fees, the contest has gone at first against the medical men. On the other hand, where medical men by presenting an organised resistance have been able to keep the sympathy of the public on their side, the imported medical men have failed to fulfil their tasks and the clubs have suffered badly.

The ethical side of the situation must not be lost sight of. The manifest impropriety of medical men taking service under lay masters has led to an important development. It was, and is, the habit of certain medical aid associations to employ canvassers who by vaunting the talent of their salaried medical officers press the claims of their institutions on the patients of other medical men. When this became known it was immediately seen that such a proceeding constituted a professional offence, inasmuch as a medical man was doing, or permitting to be done for him through the agency of another, a thing which could be construed as advertisement, and advertisement is an “infamous” act in a professional sense. The General Medical Council took this view, when the matter was brought to its attention, and decided

that the use of agents and canvassing to secure patients must be condemned. This support from the disciplinary tribunal of the profession put heart into the resistance to the tactics of the medical aid associations, with the result that many local organisations of medical men now exist for the purpose of taking combined action in support of claims for fair remuneration. The General Medical Council remains unchanged in opinion as to the undesirability—to use no stronger word—of medical men serving lay associations upon unprofessional conditions, and although there are many such associations in existence, their medical officers are alive to the situation. Canvassing has been stopped, and in some quarters a desire to meet the views of the medical profession has been manifested.

CHAPTER V

THE ABUSE OF HOSPITALS

The Spread of Hospital Abuse.—The Birmingham Hospital Saturday Fund.—Working Men's Subscriptions.—The Municipalisation of Hospitals.—The Place of the Provident Dispensary.

NEXT to the evils of contract practice perhaps those which follow upon the abuse of hospitals weigh most hardly on the general practitioner. The subject has been much written upon, but, however threadbare it may appear to be, it must receive notice here, because no record of the present state of the medical profession can otherwise be complete, because from year to year the abuse grows and takes on fresh features, though the substance of the abuse in all instances is the same; and because it lies largely with the public to abolish a wretched condition of affairs.

Everyone knows that institutions which are avowedly and necessarily supported by charity admit to their wards or their out-patient departments, for gratuitous advice and treatment, sufferers who can pay for medical assistance. The extent to which this occurs is very large, and under such methods four sets of people are defrauded—the charitable public, the honorary staff of the hospital, the general practitioner, and the genuine poor; the charity is

used for purposes for which it was not designed, the medical profession loses fees for medical service, and the class of sick persons to whom hospital aid is due is elbowed aside. The abuse is of quite old standing. Thirty-six years ago Joseph Sampson Gamgee, a well-known Birmingham surgeon, founder of the Hospital Saturday Fund and a most liberal and enlightened thinker, pointed out the bad management prevailing in the out-patient departments of hospitals. He complained that the treatment consisted in the mere administration of physic in all cases, to the neglect of full inquiry into the cause of the disease, and of well-considered advice for restoration to health. In so doing he did not mean to blame those responsible for the treatment, for he must have been aware that the circumstances which justified his words were brought about by the permanent overcrowding of the departments. Since this date the evil has grown worse. The number of out-patients attending the ninety-two London hospitals has been shown by Mr. C. S. Loch, Secretary of the Charity Organization Society, to have increased from 1,082,259 in 1887 to 1,448,026 in 1897 and to 1,584,987 in 1900. Mr. Loch submitted these figures to a meeting of the British Medical Association held in Manchester in 1902, at which meeting a valuable discussion took place which revealed the evil as on the increase in many parts of the kingdom, and there is no evidence to show that any arrest has taken place. The number of hospitals, particularly of special hospitals, has increased; the number of beds has been raised in existing institutions and special departments have been added, while in many cases there has been no

corresponding addition made to the *personnel* of the medical staff. As a result the thorough performance of their work cannot always be expected from the medical staff and a valid excuse for the scamping of duty has been established in the highest departments of medical practice. From the north and south of England, and as much from such great towns as Manchester and Birmingham as from London, the complaints of general practitioners now come that the competition of the hospitals, especially of the out-patient departments of hospitals, is ruinously unfair. From the more populous centres in Scotland and Ireland, especially from Belfast, we hear the same story, and the trouble is as rampant in the United States as with us.) A paper by Dr. George W. Gay, Senior Surgeon to the Boston City Hospital, published at the beginning of 1905, alleged that half the entire population of the capital of Massachusetts consulted one or other of the seventy-five hospitals of the city during 1903. This calculation displays an amount of abuse that seems almost incredible, but in New York and Philadelphia respectively twenty-five per cent. and twenty per cent. of the population are gratuitous hospital patients.

The abuse has not grown up as the result of any apathy on the part of the medical profession, for general and consulting practitioners alike have seen the evil arising and have taken some measures to repress it. Medical men representing such typical medical centres as Liverpool, Bristol and Brighton, as well as Manchester and Birmingham, have met and discussed the various efforts that have been made by hospitals from time to time, with the

view of preserving their benefits for fitting objects, and experienced laymen have assisted at these conferences. The means of inquiry into the pecuniary positions of patients, the use and abuse of letters of recommendation and the charge of fees to patients have all been inquired into, and the widespread nature of the evil has been made manifest, but no general and effective plan for the mitigation of the evil has been arrived at, either in this country or in the United States.

Hospital abuse, like the abuse of contract practice, is an expression of the uncertainty among medical men as to their professional aims, so that what one man considers to be philanthropy another considers to be mischievous weakness. Hospitals and their medical staffs claim credit for their work and subscriptions from the public on the ground of the numbers seen at the out-patient departments. The quondam students at those hospitals and pupils of those consultants declare that their most harmful rivals in practice are just the institution and the staff from whom they have the best right to expect help. In some towns the working-class vote predominates in the management of hospitals, and this is a fact the bearings of which have not received sufficient attention. There is no reason why working men should not contribute their share to the public charities, but that is not the way in which working men view their subscriptions to hospitals. They have been accustomed to subscribe to friendly societies, to medical aid clubs, to slate clubs, and to trade unions, and similar institutions of all sorts. In each and every case the money which they give comes back

to them in hard cash or in services rendered, and, further, they generally have a vote in the management of the funds which they thus raise. Consequently they imagine that if they support the hospitals they should not only have a vote in the management of the hospitals, but that the hospitals are bound to render them services in exchange for the money subscribed. The workmen do not give to the hospitals as an act of charity, but they pay so as to wipe out the charitable aspect of the institution. They propose to purchase, as it were, a right of entry to the hospital and a right to be treated not as the recipients of charity, but as provident people who have insured themselves against the risks of sickness or accidents. This is the feeling that undoubtedly prevails, though it has not yet been formally inscribed in any document, agreement, or covenant. The growth and development of the Birmingham Hospital Saturday Fund is very significant. Eight years ago 75 per cent. of the workmen of Birmingham subscribed to this fund and raised about £15,000 in the year, while the sum which is now subscribed by them amounts to little short of £20,000. As most of the money is raised by means of penny weekly subscriptions, and as the total population of Birmingham, including women and children, is very little over half a million, it is safe to say that the vast majority of the working men are subscribers. When working men know this they must feel that they are masters of the situation, especially as with the increase of working class support there has been, and will be, a decrease in the amount of subscriptions received from the

wealthier classes. Is it not inevitable that the subscribers of so large a sum in the aggregate should forget the infinitesimal character of their individual subscriptions, should overlook the charitable foundation of the institutions under their patronage, should ignore the gratuitous quality of the medical attention which they receive, and should generally conduct themselves as the recipients of that for which they have paid ?

In certain industrial districts in the north of England the workmen, conceiving that they are paying for the treatment they receive at the hospitals, have begun to maintain that they have a right to a voice in the government. This is the direct beginning of the municipalisation of our charitable institutions, for if the majority voluntarily tax themselves to obtain control of the hospitals, they will soon demand that the minority should be coerced into paying their share of the required contributions. The subscription would thus be converted into a rate, and the municipal administrators would manage the general hospitals as they already manage the hospitals for the treatment of the insane and for the isolation of infectious cases. This may represent the extreme outcome of the present situation ; but unless the hospitals take measures to obtain the bulk of their financial support from the wealthy and well-to-do classes it is the obvious issue. And here some may say, What of it ? They point to the financial condition of some noble hospitals in the centre of rich cities, and ask if it would not be better to end the perpetual begging of these great charities by placing them at once upon the rates. To medical

men the only answer possible is, No; and I think that those members of the public who have given real thought to the matter—they make up a woefully small number—will be in concord. When grave doubts as to the purity of hospital administration existed, as they did half a century ago, the movement towards rate-supported hospitals was a natural one. In those days the wealth of some of the hospitals, especially the London hospitals, the value of some of the lectureships, and the nepotism of some of the managers, made the suggestion of public control reasonable. Alas, that wealth has in most cases gone, and with fair competition for appointments and meagre payment for lectureships have vanished the arguments for municipalisation of the charities. Medical opinion on this matter is backed by shrewd and influential leaders of men—men of the unequalled social experience of His Majesty the King, men of the bottomless purses of Lord Rothschild and Mr. Beit, men of the business instincts of Sir Sydney Waterlow and the late Sir John Maple. They have all seen that the poverty of the hospitals ought to be met and allayed by charitable offering, so as to preserve the present relations of the hospitals towards the public. A big general hospital supported by the rates, and therefore governed by the municipality, would inevitably get out of touch with its medical officers. Men would obtain junior and senior staff appointments at the hospital for other than the excellent reason that their scientific work was the best available at the time of the vacancy; the medical officers would be unrepresented or powerless at the meetings of the

governing body, and would speedily find themselves unable to do their beneficent work without constant friction or submission to a position of complete subservience. Over and over again it has been demonstrated that medical work must suffer if all initiative is taken away from the medical profession, and that a hospital cannot be managed without the medical staff having a proper voice in the management. The honorary staff of a hospital under existing conditions obtains this voice; in their wards they are the main authorities, in the choice of their fellows they have much influence, and in the choice of their subordinates they have almost the power of nomination. A member of the honorary staff of a hospital feels his high responsibilities. He gives his services because he has those responsibilities, and is repaid by public consideration. The public know of him that he has been chosen for his attainments and character by men of his own profession, and that he is in more than a nominal sense a trustee for the conduct of a great charity. He owes it to the public, to his colleagues, and to himself to do his work without stint, and almost without exception he pays his debt. Would the public or the sick poor obtain services of the same quality if the medical staff of our hospitals were appointed by a municipal body, with all the liabilities of such bodies to political influences and social and private bias? No one who has thought about the matter can have a shadow of doubt what the answer must be.

Hospital abuse comprises under a brief title large questions, larger than have been recognised by many who have talked and written at length upon the

matter. Hospital abuse is one expression of a desire on the part of the public to obtain medical assistance at the lowest possible price, and it is as part of a resistance to such tactics that the remedy must come. For the present the question has entered into a vicious circle and every step aggravates the difficulty. The workmen giving such large sums in the aggregate do not see that they are not contributing their just quota, and are not really paying for service rendered. They give pence but think in terms of thousands of pounds. The more hospital abuse prevails the more disinclined will the well-to-do classes be to subscribe, for the knowledge is abroad that the money of the charitable subscribers is being misapplied. The amount given decreases, and this leads the managers of hospitals to rely more and more on the subscriptions of the working classes, and to refrain from making inquiries when cases of abuse come before them. It is towards breaking this vicious circle that efforts should be directed. The agitation against hospital abuse has led to a few reforms here and there, but such sporadic attempts at remedy do not meet the case. What is required is education of public opinion. The public should be helped to understand the fact that machinery to some extent really exists to deal with the whole situation, only it is improperly used owing to the eccentric ignorance that prevails among all classes. An injured man or a sick woman turns at once to the nearest hospital for aid, the out-patient department becomes grossly crowded, and the real sufferers are thrust to the wall by applications for assistance, justified neither by the plight of the patients nor by

their circumstances. The public should be taught to regard the family practitioner as the first source of help, and where the means of a patient do not permit of his employing a medical man in a private capacity, provident dispensaries which are properly conducted, and other legitimate forms of combination, should be resorted to. The public and the general practitioner should alike regard the out-patient departments of hospitals as the poor man's consulting rooms, and only such cases should be drafted to these departments as present difficulties in their treatment. Combination among the public has long been seen by the medical profession to be the solution of the problem of medical assistance for poor people ; it is only unfair combination, leading to a necessary lowering of professional standards, to which objection is offered. In order that provident dispensaries may take the place of the out-patient departments of hospitals, as far as the necessitous sick are concerned, some increase in their number and some standardising of their methods are required ; but if the genuine economy of such institutions were more widely perceived, there would be no difficulty in these improvements. The exact place of the general practitioner's surgery, the provident dispensary, and the out-patient department in a general scheme for the treatment of the sick poor should be defined and understood ; then, and perhaps then only, shall we begin to solve the problems of hospital abuse and to remedy the evils of immoral combination. When, in addition, the public perceive that the gift of pennies, even though systematically given and amounting in the aggregate to a large sum, does

not confer a legal right to obtain the gratuitous services of the staff of the hospitals, and when, as a matter of course, there is an understanding between the local practitioners and the staff of the neighbouring hospitals, whereby the practitioners may feel assured that the hospitals will not wilfully take their patients from them, two of the glaring grievances of the medical profession will rapidly abate. And simultaneously the public will enjoy better medical assistance, for it is impossible to imagine anything more inadequate and perfunctory than much of the treatment that is prescribed at the over-crowded out-patient departments of large general hospitals.

CHAPTER VI

THE EVILS OF QUACKERY AND UNQUALIFIED MEDICAL PRACTICE

The Prevalence of Quackery.—Quack Advertisements.—Prescribing Chemists.—The Pharmaceutical Society and Dispensing by Medical Assistants.—The Prescribing Optician.—Registered Midwives.—Parish Nurses.—The Prescribing Parson.

QUACKS there have always been and quacks there will always be, but the immunity enjoyed now-a-days by quackery is remarkable, almost incredible; and when its effects on our generation are noted, it is impossible not to wonder that no suggestion is ever made, save by medical men, that the law should attempt to find a remedy. Specific charges have been brought against quacks by their dupes, but almost always it has been found that the charges were not sufficiently susceptible of proof to warrant conviction.

The licence enjoyed by irregular practitioners of medicine—by persons, that is, who possess in the legal sense of the word no licence whatever to practice—is absolutely wonderful. It would be ludicrous if it were not so sad. Medical electricians, medical hypnotists, medical botanists, and medical masseurs on the one hand, and the votaries of “safe medicine,” bone-setters, and the proprietors of patent

remedies on the other—all are ready to treat the community for every sort of pathological condition, and all claim to be the depositories of therapeutic secrets which have been denied to the intelligence of men who have made surgery and medicine the study of their lives, and who have stood the test of examinations as to their knowledge. Surely but very little thought bestowed upon this situation should enable the dullest to see that it is a highly ridiculous one, and one that reflects in no creditable manner upon public astuteness and good sense. Yet the ignoramus and the product of the highest culture will alike seek the administrations of the quack, and of the two the latter appears sometimes to fall the easier victim. The public have to choose the fittest people for their medical advisers. The competitors for their suffrages are two—(1) the medical profession, consisting of a body of trained and educated men, tested in all the necessary scientific requirements; and (2) the irregular practitioners, whose credentials are simply their own assertions supported by the corroborative evidence of satisfied patients. Which body is more likely to be the really learned one? In every other profession or walk of life the public would at once give their vote in favour of the properly trained body whose proven accomplishments speak for it. In every other profession or walk of life self-presented testimonials receive the exact attention from the public to which they are entitled, while testimonials from outside are subjected to some scrutiny. In medicine alone over such obviously necessary precautions is hesitation to be observed. It is easy to see what are the prominent factors which

have brought this state of affairs about. Many disorders tend towards recovery ; aggravation of these complaints by inappropriate treatment does not necessarily obviate recovery ; there are no limits to the imagination of the hypochondriacal and hysterical subject ; and there are many diseases, especially diseases of the nervous tracts, the natural course of which is one of remission alternating with exacerbation. The quack fosters every possible delusion in his patients which can arise from these circumstances and reaps a harvest of eulogy, which he immediately prints and disseminates. The bulk of the testimony in favour of unorthodox methods may be obvious and fraudulent concoction, but a certain amount represents the genuine delusion of weak and ignorant patients. Every medical man receives such testimony to his apparent ability, but, knowing its worth, he keeps the communication of his patient to himself, whereas the quack blazons it abroad, and so, with the favour of the press, is enabled to secure new gulls.

For undoubtedly nowadays the quack is strangely favoured by the press. The subject of quacks' advertisements is one upon which public opinion stands much in need of being both formed and stimulated. The discredited quack, when once his methods of doing business have been exposed, secures plenty of reprobation, leading articles denounce him, and certain newspapers refuse his advertisements. But the prosperous quack appears to have his own way with the world. That the general public should be misled by bold advertisement and garbled testimonials is no matter of surprise and, indeed, is too natural to be

even a matter of complaint. That a certain amount of quackery should pass muster with the lay press as a form of commercial enterprise can be understood. A newspaper editor or manager may be pardoned if he thinks that the use of his columns to make a nostrum known is a legitimate branch of newspaper business, especially when it is remembered that if he took the opposite view the proprietor of the newspaper might be willing to hear of his resignation. But while this is true with regard to some advertisements it is not true of others, and the disgusting advertisements of many modern quacks ought to be tolerated by no self-respecting editor, manager, or proprietor. Yet no falsehood is too shameless, no promise too palpable a trap, to be refused currency in the advertisement columns of some of the best-known journals, and it is noteworthy that among the worst offenders in this respect are newspapers and magazines which enjoy with certain classes of the community a high reputation for accuracy and *bona fides*. Regard being had to the lavish expenditure which is bestowed upon advertising some quackeries, it is obvious that those who take toll of the advertisers are participators in the proceeds of this sinister traffic. There have been, it is to be feared, flagrant cases in which an extravagant advertisement has been the price of corrupt silence or even of venal praise on the part of the press. Such practices stand in no need of condemnation. There have been again cases in which, while there has been no such confession of infamy as is applied in a bribe, yet the scale and tenour of the advertisements bore a vicious relation, a high price being asked for a filthy adver-

tisement. Not long since some of the most popular newspapers in the country were accepting regularly the advertisements and money of a crowd of scandalous persons engaged in selling so-called "female remedies." The essence of these advertisements was a promise to pregnant women that certain pills or potions would cause abortion, so that the woman who bought them was either aided in an attempt at crime or else swindled out of her money. By dealing complacently with such customers the editor or the proprietor of a journal, whichever of them may happen to be responsible, makes himself a party to an odious and despicable kind of fraud. The weak, and especially the weak woman, the ailing, and the poor are the chosen victims of the quack. By playing on their fears and taking advantage of their distresses the quack persuades them to pay exorbitant prices for his worthless goods. Thus does he obtain command of the sums of money which he lavishes in advertisements, and those who cultivate his custom must not complain if they are charged with complicity in his misdeeds.

It is earnestly to be hoped that some attempt will be made soon by legislation to counterbalance the evils of quackery. Medical practitioners are not the only, or even the chief, losers by the mischievous frauds of quacks. The whole country suffers from their evil machinations, and it is a thousand pities that hardly a voice but that of the medical profession is ever raised against them. The opposition of the medical man to the quack, however legitimate, cannot be called disinterested, and therefore does not weigh with the public.

The practices of certain persons who are allied to the medical profession, but who, not content with an ancillary position, try to usurp professional work and to encroach upon the province of medicine, may come in for comment here. These people cannot be called quacks, but, being unqualified, they do the work of qualified persons. Prescribing druggists who give medical advice, and opticians who take upon themselves the work of the neurologist are cases in point. The methods of both these classes have long formed a legitimate subject of complaint among medical men, and although the harm that is done by their practices may not be very large, it certainly shows no tendency to grow less.

The Pharmaceutical Society very properly and strictly forbids its members to prescribe for patients or to take upon themselves the functions of the medical practitioner, but over the counters of scores of dispensing chemists every day and every hour there are given to the public medical advice and medical treatment. There is nothing illegal in the situation, for any unqualified person may give or sell medical advice to anyone else so long as he or she does not pretend to have legal justification to do so. (This must be kept constantly in our minds.) But although no law is broken so long as the dispensing chemist lays no claim to the position of the registered medical practitioner, yet the public are invited to take risks—not always so small as they seem—when they submit their ailments to the diagnosis of the non-qualified man; while an unfortunate separation of interests is created between the medical man and the dispensing chemist. The advisability of the

action of the dispensing chemist in prescribing for the maladies of the public is not often defended by anyone. No serious argument can be founded upon the fact that in an emergency the druggist's shop is the natural place of resort. Among his wares will be found undoubtedly the usual stock of restoratives, styptics, bandages, and the like. But the prescribing chemist does not make his harvest out of chance accidents; he has a steady flow of clients who consult him. A defence of counter-prescribing is sometimes attempted on the ground that medical practitioners transgress the boundaries of the dispensing chemist's territory when they dispense their own medicines. And this brings us to a question concerning which there is some difference of opinion among medical men. Is it right, proper, and advisable for medical men in any circumstances to make up and to dispense their own medicines? The answer, of course, is Yes, but even while we say "Yes," we may regret that we cannot answer differently. Undoubtedly it would be advantageous to the medical profession in every way if medical men prescribed their medicines only, leaving the making up of the formulæ to the dispensing chemist. The practitioner would appear to his patient's eye as the dispenser of medical knowledge and as nothing else, and the patient would understand that his fees were due to the member of a scientific profession and not to the retailer, however distinctly scientific a branch of business the retailer may be engaged upon. There have been many suggestions to make it unprofessional for medical men, save in emergencies, to dispense medicines, and quite recently one of the most important branches of the

British Medical Association was asked to pass a proposal, to which effect was later to be given in a Parliamentary Bill, that medical men should cease to dispense. The meeting would have nothing to do with the motion, because practical members of the Association were alive to the actual conditions obtaining in practice. They could see that though the dignity of the medical profession might gain by the divorce of its practice from dispensing, the alteration was not feasible. There are many neighbourhoods which are too poor and too sparsely populated to support a dispensing chemist, so that to make it incumbent upon the public to take their prescriptions to the druggist's shop would be impossible. And if it were not impossible it would not be wise in the present state of public knowledge and opinion. Apart from the fact that a poorly-paid class of professional men make a small profit by dispensing their own medicines, the public—especially the uneducated public—put faith in a medical adviser who is prepared with a material remedy as well as with spoken precepts. It is a pity that this should be so, but as it is so we cannot ignore the existing sentiment. It is quite easy to see that the medical profession would gain in repute by leaving dispensing alone, but as yet the change cannot be made.

This will be a convenient place to allude to the action of the Pharmaceutical Society which has proceeded recently against members of the medical profession in Scotland for infringement of the Pharmacy Acts, for if the Pharmaceutical Society had succeeded in establishing its whole case something like a forcible division between the practice of medicine and the dis-

pensing of medicine in one part of the United Kingdom would have been accomplished. At the winter meeting of the General Medical Council in 1900 a medical man was summoned to appear before the Council upon the following charge, preferred by the Pharmaceutical Society :—

“ That he, being a registered medical practitioner, habitually employs as assistants for the sale of drugs and poisons persons who are not qualified to act as chemists or pharmaceutical assistants, and thereby causes such persons to commit breaches of the Pharmacy Acts.”

It was alleged for the Pharmaceutical Society that practices had arisen in Scotland which broke the law, inasmuch as many medical men owned chemists' and druggists' shops with a surgery attached at which they attended only for two hours or so, the premises being left for the rest of the day in charge of an assistant not qualified under the Pharmacy Acts of 1852 and 1868. The Pharmaceutical Society asked the General Medical Council to regard this situation as constituting “ covering,” the assistant doing medical or pharmaceutical work under the name of his principal. The General Medical Council considered that the Pharmaceutical Society had made out its case, and the Society proceeded to secure more convictions. The defence of the practitioners was that assistants qualified under the Pharmacy Acts could not be obtained in Scotland ; that all over the West of Scotland the practice complained of was habitual ; that the unqualified assistant received instructions not to sell poisons save under the supervision of his principal ; and that the legitimate employment by medical

practitioners of dressers and midwives formed a precedent for what was being done. Protests against the view taken by the General Medical Council were addressed to the Council by influential members of the medical profession in Glasgow, but the position taken by the Society was a perfectly sound one, though the conditions of life made the provisions of the law, when strained in their interpretation, impossible to obey. To compel every medical man to keep a qualified assistant to dispense for him is not possible, and the alternative course of employing a dispensing chemist cannot be insisted upon. A dispensing chemist will only be found in a neighbourhood which will support him in the exercise of his calling, and until this fact can be got over any attempt to make it compulsory upon a medical man to employ a dispensing chemist must be futile.

Another unqualified rival to the medical man, and one who has lately become active, is the prescribing optician, or "optologist," as it has been proposed to call him. The medical man's view of the optician is that he should be an instrument maker and should sell to the public glasses in accordance with the formulæ supplied by the practitioner. He should not consider that a knowledge of optics, whether shallow or profound, fits him to prescribe glasses for the public, because the symptoms of disordered vision require a general medical education for their elucidation. The optician's view of the optician would sometimes appear to be very different. Hear him on himself: "It behoves the optician to know something of anatomy and physiology in general and of the anatomy of the eye and the physiology of vision in particular. He

should have some knowledge of neurology and the various nervous ailments which are directly caused by, or dependent upon, eye-strain. He should have some knowledge of ophthalmology in so far as it includes the various diseases of the eye, not for the purposes of treatment but for its prompt recognition in those who apply to him for glasses, in order that intelligent advice may be given the patient to seek medical assistance before the pathological condition has become chronic or incurable." The passage is quoted from an address delivered before the Atlantic City Convention of American opticians, and the views are said to be those of English opticians. The optician described in the address would be more than half a medical man if his attainments would stand the test of examination. Opticians and the attendants in their shops do not necessarily pass any test at all, and we may take it for granted that, as a class, they have not any medical knowledge. As far as simple optical principles are concerned the optician is, or ought to be, capable of giving as good an opinion as the medical man. The glasses that he can supply may be quite as correct as those prescribed by the medical man, compensating accurately and perfectly for the defects of the patient's eye; but, unfortunately, in many cases the glasses are none the less unsuitable and should not be worn. Many circumstances have to be taken into consideration, of which the optician, even though he have some acquaintance with neurology and ophthalmology, is no judge. The general health of the patient, his avocation, the conditions under which he works, the length of time during which the glasses should be

worn, are all points upon which the medical man is better qualified to give an opinion than the optician. The eyes are organs in which faults of shape and alterations of function incidental to advancing life are frequently complicated by physiological defects and pathological changes of a serious character. The knowledge of the qualified medical man should cover the whole range, the knowledge of the optician at the very best covers only a small and comparatively unimportant portion.

There is no doubt that the optician to-day does largely test sight and prescribe glasses as well as sell them, and this branch of unqualified practice, which used to be confined to the maker of optical instruments, has now been taken up by the prescribing chemist under the title of "chemist-opticians." The innovation is defended by the assertion that there are not enough qualified medical men with ophthalmological knowledge to do the work required by the public. This resembles the reply made by the medical man when he is asked why he performs the office of the dispensing chemist, and it is a correspondingly good reply. It does not, however, make what is wrong right. The remedy for the situation is simple and the General Medical Council is aware of it. The examining bodies must hold special and careful examinations in sight-testing and ophthalmology so that no medical man for the future can obtain a place upon the Medical Register without being able to deal with all ordinary ophthalmological questions.

The gross impositions of the quack, the unfair tactics of the medical aid associations, the immoral

use of hospitals, and the ill-instructed rivalry of the druggist and the optician do not complete the troubles of the general practitioner. There are others who should be his assistants and who prove to be his rivals, namely, district nurses, parish nurses, and registered midwives. The mischief done by all these persons is sometimes exaggerated, but their frequent usurpation of medical functions is undoubted. It may be remembered that when the movement which led to the existing Midwives Act was taking shape not a few medical men were seriously perturbed, foreseeing in the registration of midwives the creation of a lower order of general practitioners, who would be able, because of an inexpensive training and an incomplete curriculum, to undersell the qualified medical man. Other medical men considered that the registration of midwives must be supported as the measure would secure to the parturient poor safe assistance in their need. There was this noticeable thing about the difference of opinion expressed by the two camps into which the medical profession was divided—they advanced the same claim for their views, viz., solicitude for the parturient poor. The majority of the general practitioners opposed legislation for the registration of midwives because they believed that the midwifery practice of a large proportion of the country would fall to semi-qualified people, in whose hands a little knowledge would prove to be the proverbially dangerous thing. Conversely, a system whereby any woman, however ignorant, could attend another woman in childbed, without any check being imposed on the possibility that she might not only kill the patient but constitute herself a focus

for the spreading of puerperal fever, was wrong—obviously and terribly wrong. The Midwives Registration Bill was therefore not so much a Bill for the relief of the sick poor as a Bill for the good of all classes. Legislation was required which would protect the poor from the ignorant, dirty, and degraded practices of certain so-called midwives, which would protect the public from the spread of puerperal fever, and which would be able to supply an order of midwifery nurses who would not trespass upon the proper precincts of medical practice—who would not, in fact, practise in contravention of the Medical Acts. The present legislation is an honest attempt to arrive at a middle path between the desiderata. It is admitted that those who argue that the position of medical men under the Medical Acts has been encroached upon by the creation of an order of semi-qualified persons have still a forcible cry, but inasmuch as midwives are a recognised institution, to speak of dispensing with them, as has been done by some of the fiercer upholders of professional privilege, serves no purpose. Midwives must exist and must be made into a clean, reputable, educated class, though their use will be to a certain extent anomalous. The registration of midwives, in so far as it takes the midwifery practice among the lower orders out of the hands of the medical profession and confides it to a semi-qualified class, is, in fact, a retrograde step. For just as the agitation in favour of the registration of midwives was at its height the General Medical Council abolished the unqualified assistant because he was only partially trained, and one of his chief uses

was as obstetric adjuvant to his principal. That is to say, that an Act of Parliament now allows women to do what a by-law of the General Medical Council has forbidden men to do. Again the Act by allowing practically all pre-existent midwives to register has temporarily legalised the "Gamp" against whose ministrations it was aimed. In the future the full benefit of the Act will be felt, but for the present the public and the medical profession alike have but little cause of gratitude.

And the same position that is so obvious in the case of midwives exists in the case of district and parish nurses. If these women are unscrupulous in their interpretation of their duties they can supplant the medical man. Undoubtedly, the services of such nurses are of great benefit to the community, but undoubtedly also by preventing medical assistance from being called they have proved now and again a source of danger. As a rule the district and parish nurses do not take medical duties to any great extent upon themselves, but they are apt to breed mischief by preferring to work with certain medical men to the exclusion of other medical men, and for a medical man to be dependent upon the patronage of a nurse is as galling as it is for him to be ousted from practice at the caprice of a nurse. Occasionally a parish nurse is backed up in her wayward behaviour by the parish clergyman, and then the medical man, if he is not in favour with the clergyman, is indeed likely to have scant justice dealt him. Clergymen, especially English country clergymen, are known to have violent medical opinions and prejudices. Many of them, like

Sydney Smith, prescribe for their parishioners, but they do it without the great humourist's medical education and natural shrewdness. Woe to the country practitioner who ventures to reprove the prescribing parson !

CHAPTER VII

THE NAVAL AND MILITARY MEDICAL SERVICES

General Considerations.—The Army Medical Service.—The Old Abuses.—Semi-Military Titles.—A Royal Corps.—The Boer War.—Mr. Brodrick's Committee.—The Present Warrant.—The Indian Medical Service.—The Old Grievances and the New Warrant.—The Language Examination.—The Treatment of the Civil Side: Bad Pay.—The Naval Medical Service.—Re-organisation and Redress.

MEDICAL officers of the army, of the Indian Service, and of the navy are appointed after a competitive examination between candidates, who must be duly registered medical practitioners, British born, and between the ages of 21 and 28 years. The examinations are fairly severe, but their competitive character on some recent occasions has undergone no serious test, owing to lack of aspirants for commissions.

The full particulars regulating the position of the medical officer in the army, in the Indian Medical Service, and in the navy will be found in the official warrants of the respective services, and no purpose would be served by reproducing them here. But while it is unnecessary to go with detail into the conditions under which commissions are granted, it is important briefly to review the state of the three

Services in respect of *personnel* and emolument. Although none of them calls for many officers, still, taken together, they constitute a considerable section of the medical profession, and a highly important section when the nations of Europe are armed to the teeth for the preservation of peace, and when the issue of the Far Eastern struggle, despite the declaration of peace, is still a matter of guess-work. Good armies and good navies require a good medical service—indeed, they are neither good armies nor good navies without one—and the relations of the medical man to the public could not be better exemplified than by an inspection of the position which is occupied by the medical men in whose charge the health of our army and of our navy lies. There is also this great practical use in discussing the status of the medical officer of the army, of the Indian army, and of the navy—improvement may follow, and has followed, where abuse has been proved to exist. The conditions of service can be altered at any time at the will of the authorities, so that amendment can result quickly if the need for amendment can be shown. It is quite different with most of the circumstances which, as we have seen, tend to detract from the happiness and the utility of civilian medical life. These are due, mainly at all events, to the social condition of our country at the present day and are not capable of immediate reform. The depopulation of the rural districts and the half-education of the masses have had influence in bringing about the abuses of contract practice and wholesale resort to quackery, which cannot be altered at once by legislation. The

natural course of progress towards better things can be assisted by intelligent legislation, but Parliament cannot at one stroke remove grievances which are dependent upon general factors in modern sociology. The exact opposite prevails in the naval and military medical services. The terms of employment are concrete, and by the alteration of a regulation here and there the lot of the employed can be at once transformed, their pay can be raised, their burdens can be lightened, and their position made in every way better.

Despite the abuse that has been freely dealt out to the Admiralty, the War Office, and the Government of India because of their unsympathetic attitude towards their medical services, it will be seen that the position of the officers of all three departments has been altered quite recently for the better in response to representations. The scientific ideal of our great bureaux is not high when medicine is in question, but it is stupid to represent the departments as wantonly and purposely unfair towards the medical man. Moreover, medical men have themselves much to answer for if the scientific side of medicine is occasionally belittled. Professor T. Clifford Allbutt, Regius professor of medicine in the University of Cambridge, recently called attention to the unscientific or even anti-scientific tone of the Army Medical Service as exercising a deterrent effect on medical candidates of a superior class. He spoke as being in possession of information showing that the senior medical officers in this Service have a lack of appreciation of the scientific work of their juniors. "Science doesn't pay" expresses the views of these

military-minded persons, and this is the spirit which has damaged the three Services so much and which, if it is not eradicated, will even now prevent their resuscitation.

The three Services are taken in the following order: the Army Medical Service, the Indian Medical Service, and the Naval Medical Service, and in each case the old abuses are considered alike where they influence existing conditions, the present circumstances of employment, and the chances of improvement. In the case of the Indian Medical Service I have entered purposely with considerable detail into the matter of pay, as in this Service the pay is distinctly bad. The scale on the civil side has not been altered for thirty years, and unless alterations are made with promptitude the Government of India will be embarrassed seriously by the dearth of medical officers.

THE ARMY MEDICAL SERVICE.

The Army Medical Service has been the best abused section of the medical profession. The public has slighted it, the War Office has neglected or mismanaged it, and its members have been in prolonged revolt against their conditions of employment. During the "eighties"—and no further retrospection will be attempted—the Service was full and fairly popular. The instruction at Netley, being entrusted to professors for whom no provision for superannuation or retirement had been made, tended to fall behind modern standards, but the public did not lose much by this, for there was good competition for the commissions and a fairly able class of

surgeon-on-probation was recruited. But a change came over the face of things in the next decade. That the conditions of employment were in some respects unfair became manifest. For example, it was not easy for an officer of the Army Medical Service to obtain satisfactory sick leave on full pay. He could have six months' sick leave on full pay, and this leave was renewable once. After that he went on half pay, unless the medical board from the first gave him a prolonged leave for his recovery—a privilege which was rarely if ever granted. Again, at a time which was marked by many-sided developments in medical knowledge, when in all the medical schools of the country the more brilliant and ambitious students were striving to benefit by the results of modern research, the Army Medical Service offered no inducements to scientific men. Thirdly, a difficulty experienced by the officers of the Army Medical Service in obtaining entrance to "Service" clubs was not calculated to increase the demand for commissions. And so, for this reason or that, the applications fell off and competition became a pretence, for there were more vacancies than candidates. In 1891 came a new warrant, which it was hoped would meet a case to the seriousness of which the War Office was awakening. This warrant provided that the officers of the Army Medical Service should have sick leave on full pay on the same conditions as those laid down for regimental officers, and at the same time the designations of the departmental ranks of the Army Medical Service were altered by the granting of semi-military titles. The question

of the use by medical men, who are officers in the army, of military titles is an unsettled one still in many minds. But the officers of the Army Medical Service were almost unanimous in their desire for this innovation, as being calculated to make their general position less insecure and anomalous; their brother officers of the Indian Medical Service had the same opinion, although not perhaps quite to the same extent; both were heartily backed in their views by the British Medical Association, and the warrant granted their desire. But the Army Medical Service did not become more popular, the position of the officers did not improve, and the competition for commissions grew no severer. One class of young medical men were kept from joining the army by the difficulties that they heard would be put in the way of any desire to do original work. With another class the exclusion from "Service" clubs rankled, for many good men, forming the material from which members of a medico-military corps ought to be drawn, felt strongly that it would wound their self-respect to join a Service where they were regarded by their brother officers as good enough to work with but not good enough to play with. Lord Wolseley, at that time Commander-in-Chief, was believed, with some show of reason, to view with dislike any acquiescence in the claims of the medical officers. Notwithstanding the multiplication of military-medical duties both at home and abroad, and notwithstanding the increase in the size of the army, the *personnel* of the Army Medical Service was less by 400—*i.e.*, about 30 per cent.—than it had been after the Crimean war. The

depletion of the establishment produced an unfair incidence of foreign service, great difficulty in obtaining reasonable private leave, and a constant change of station, whereby hardship and expense were entailed upon officers of moderate means, especially if married.

In 1898 another new warrant was issued, under which the Army Medical Service took its place as a Royal Corps side by side with the other scientific branches of the army, namely, the Royal Engineers and the Royal Artillery—a position which reformers had contended that it should properly and legitimately occupy. At the same time, and in analogy with the use of military titles by the Royal Engineers and Royal Artillery, such titles were assigned to medical officers up to and including the rank of colonel, so that there could no longer be any doubt about the exact army rank of the officers of the Army Medical Service. The warrant dealt simply with the constitution of the new Royal Army Medical Corps, but the regulation with regard to the use of purely military titles afterwards came into force in the Indian Medical Service. There seemed no reason why the Royal Army Medical Corps should not now become a deservedly popular service and attract a number of well-trained candidates from the universities and best medical schools. Many senior officers thought that the concessions of the War Office would prove successful in inducing a large and good class of men to compete for commissions in the Royal Army Medical Corps at the succeeding examinations. But again nothing happened.

The grievances of the Service were so manifest

that its advantages were lost sight of and yet these were, and are, very real. Medical employment in the British army offers, as a matter of fact, unrivalled opportunities, and the records of certain officers show that it is not impossible to seize upon them. The sphere of activity is world-wide. Not even in our navy is there an equal chance of studying the diseases peculiar to particular lands, and the imagination and professional interest must be dull indeed which cannot be quickened by a consideration of the varied field in which an officer of the Army Medical Service finds himself. The red tape, of the restricting bonds of which so much is talked, has not been able to stifle much original scientific work. The pay, though inadequate, is certain, and the social conditions, if not perfect, are at any rate more dignified than those of a large section of the civilian medical profession. But some writers in the medical press, in the laudable desire of benefiting the officers of the Army Medical Service, appear to have damaged that Service by the persistence with which the darker side has always been presented. At any rate the medical profession and the teachers in the medical schools did not regard the warrant of 1898 as satisfactory, and the Army Medical Service remained nearly as short of men as ever, which meant that the hardships dependent upon undermanning remained acute. And just when the Service was in this condition, unpopular, dwindling and overworked, the tremendous strain of the South African war was thrown upon it. What followed is too well known to need more than the barest recapitulation. Splendid work was done by the officers

of the Army Medical Service, but the department as a whole came in for severe criticism. Not one of the popular books dealing with the South African campaign failed to give a chapter or more concerning the Corps; while the serious works, as well as the letters of medical men at the front, dealt with its deeds in copious detail. Explanations of, and remedies for, the deficiencies which observant writers noticed in the medical work at the front were forthcoming in every direction, while deeply ignorant persons rushed to the rescue with impossible remedies for non-existent conditions. From every side, in fact, there was offered a rich choice of prescriptions for reviving the drooping condition of the Army Medical Service. Testimony to the devotion and skill of individual members of the Corps was as emphatic as any of the criticism lavished upon the faults of the system; but condemnation produces more effect and lingers in the memory more persistently than praise, and the general idea gathered by the public was that, despite the skill and self-devotion of a few, the Army Medical Service had broken down badly. Of course, it did nothing of the kind. Its work as a department was more affected by the difficulties of transport than was the work of other departments of the army, and all criticism that lost sight of this fact, however generously inspired, was unfair.

Then came the Royal Commissions to inquire into the management of the South African hospitals, and the care of the sick and wounded (see Appendix § 1), the reports of which, forming the first well-balanced expressions of opinion upon the medical conduct of

the campaign, proved on the whole favourable to the work done by the Army Medical Service. Upon this followed the institution of Mr. Brodrick's committee for the reorganisation of the Army Medical Service, the *personnel* of which did not escape criticism. This committee in a comparatively short space of time produced a document drawn with care and ingenuity, which was received with an outburst of adverse comment. Conditions were suggested by the committee, with the laudable object of obtaining and maintaining a high standard of efficiency, which were considered to be vexatious and which, it was thought, might impede in their working the careers of many officers. The document was none the less an honest attempt to show how the Service could be placed on a satisfactory footing, and many of the apprehensions that were expressed were groundless. One of the principal aims of the committee had been to make use of selection rather than of seniority when promoting an officer to a responsible post, another had been to bring the Army Medical Service into close relation with civil professional life, and a third had been to hold out inducements to men of scientific attainments to compete for commissions—surely all good aims. Examinations that were threatened resolved themselves, when looked at closely, into tests of a practical and clinical character, almost unavoidable if the principle of selection was to be followed. Six months later—*i.e.*, in March, 1902—came the new warrant which followed the recommendations of Mr. Brodrick's committee fairly closely, and under this the Army Medical Service now works. The

Royal Army Medical Corps is placed under the supervision of an Advisory Board, consisting of two officers of the Service, two civilian surgeons and two civilian physicians appointed by the State, a representative each from the War Office and the India Office, a representative nursing matron, and the Director-General and Deputy Director-General. In this way the Service should be managed so that good men may be obtained and kept. By the warrant the Director-General is given an increase of army rank and an increase of pay. The pay of medical officers is increased and provision is made for special pay and charge pay. The door is opened for scientific and professional study and for professional merit and distinction. By one new regulation a lieutenant on probation, who at the time of passing the examination for admission to the Royal Army Medical Corps is holding, or is about to hold, a resident appointment in a recognised civil hospital, can be seconded for a period not exceeding one year, during which he is holding the appointment. While seconded he receives no pay from army funds, but his service reckons towards promotion, increase of pay, gratuity, and pension. This is a distinct bid for a high class of candidate. And other regulations seek to insure the maintenance of a good standard. An officer is eligible for promotion to the rank of captain on the completion of three and a half years' service and to the rank of major on the completion of twelve years' service, "provided that in each case he has previously qualified in such manner as may be prescribed by the Secretary of State." This regulation has seemed to some to foreshadow the examina-

tion in school work of men of mature years, much of whose time has been necessarily spent far away from books. But the belief has since grown that the subjects of examination would be as a rule of a thoroughly practical and clinical character, while it is clear that tests must be exacted if the principle of selection is to be followed. If an officer passes with distinction the examination qualifying for promotion to the rank of major, the period of service required to render him eligible for the rank of major or lieutenant-colonel is reduced. In other words, promotion now comes largely by selection. Due provision is made for promotion to brevet rank and for distinguished service, and retirement after twenty years on £1 a day, one of the most attractive features of the Service and one which was said to be in danger of alteration, is allowed to remain.

The Army Medical Service having laboured under many disadvantages and its work in South Africa having been unjustly belittled and discredited will require time to recover its popularity. But the present warrant seems to promise better things. It would be rash to prophesy more exactly, for the Advisory Board is still new to its work and can hardly be said to enjoy the confidence of the whole Service. Its functions are not as clear as they might be and there is difference of opinion as to the advisability of purely disciplinary and administrative matters being left to its jurisdiction. The selective principle has not had time to display its value, though the recent choice of a Director-General shows that it is intended to give the principle a thorough trial. Under Mr. Brodrick's

abortive army scheme the Director-General of the Army Medical Service had a seat at the Army Council, but Mr. Arnold-Forster's scheme relegates him to a place in the Quartermaster-General's department. Medical affairs would have a much better chance of being understood if they were represented by a spokesman at the Army Council and the exclusion of the Director-General from this body must be regarded as unfortunate.

THE INDIAN MEDICAL SERVICE.

In the Indian Medical Service, as in the Army Medical Service, we have to consider new conditions of employment designed to meet a growing reluctance on the part of medical men to join the Services. New regulations for the Indian Medical Service were issued early in October, 1903. An admirable Service in the past, the Indian Medical Service at no time fell from its estate to the depth that occurred in the case of the Army Medical Service. But the Indian Medical Service had manifest grievances, which were fast altering its status in the eyes of the medical profession, when the new warrant was issued, and it is, to say the least, doubtful if the remedies since applied will prove adequate. Complaints were rife which showed that unless measures of reform were granted the splendid Service to which India owes so much, and to which our Crown owes so much, was in peril of finding no men to hold its commissions. To begin with, the pay in the Indian Medical Service was poor—inferior to that of the Army Medical Service in almost every instance. Whilst

the latter corps offered to the senior medical officer in charge of a hospital charge allowance at generous rates, and specialist's pay in certain cases, no similar allowances were received by the Indian officers. For a long time it had been stated that a corresponding increase of pay to that granted to the Army Medical Service would be given to the Indian Medical Service, but the matter remained perpetually "under consideration." The low pay was the first grievance. Secondly, when an officer of the Indian Medical Service was given an appointment bringing in increased emoluments he had to pay his own passage money to take it up. Thirdly, an officer could only draw the lowest rate of pay until he had passed the language examination, but owing to the frequent moves of junior officers on first landing in the country it was often impossible for them to pass this examination for some time. Fourthly, the emoluments on the civil side, which used to be an alluring factor of the Indian Medical Service, had diminished considerably. Chiefly owing to the increasing number of trained and well-qualified native practitioners—men trained, moreover, at the hospitals manned by the Indian Medical Service—there became less scope for practice, while a limitation of private fees by the Government of India—which many regard as both unfair and objectionable—also reduced the income looked forward to by men in civil employment. Lastly, as regards promotion, a lieutenant-colonel at the age of 55 years was bound to retire on a pension of £500 a year (unless promoted) for 25 years' service, and on £700 a year for 30 years' service in similar circumstances. But

owing to the diminution of administrative posts that succeeded the amalgamation of the military medical administration of the two Services in 1880, there was practically no chance of a lieutenant-colonel of 25 years' service coming up for selection for an administrative post. He thus had to retire upon £500 a year, whereas if he had succeeded to an administrative post he would have earned a pension of £700 by the time he had passed through his term of office, plus the additional £250 a year for the holding of such posts. He lost, in fact, £450 a year as compared with former years. This is a brief summary of the grievances which awaited redress in the Indian Medical Service before the issue of the new warrant.

The new warrant at once adjusted to a substantial extent the irregularity of pay between the two military medical Services. The financial condition of the Indian medical officers, as far as concerns the military department, is now much better. The minimum sum which a lieutenant now receives after arrival in India is Rs.420 a month, the equivalent, with the exchange compensation, of £357 a year, while the officer who never aspires to anything beyond the charge of a regiment, and who serves for over 25 years, will in future draw Rs.1,300 a month, which is equivalent to over £1,100 a year. To these rates of pay every man who enters the Indian Medical Service may confidently look forward, for paragraph 9 states that "a major is promoted to lieutenant-colonel on completion of 20 years' full pay service"—there is to be no selection for that rank to which every officer who serves long enough

will attain. But while the pay is generally improved, the remuneration of the administrative posts remains much the same save that the pay of the Director-General is increased. In the case of military appointments carrying consolidated rates of pay, increases in those rates have been made analogous in some cases to the increases in the pay of rank.

Specialist pay of Rs.60 per mensem is now granted to officers below the rank of lieutenant-colonel, but the concession which reads well means very little, for there are very few appointments ever made. Extra furlough is granted to officers who want to take up a special course of study, at the rate of one month of such furlough for each year's service up to 12 months in all. The pensions are increased, that for 20 years' service being raised from £1 per diem to £400 per annum, that for 17 years' service being £300 instead of £292; while Clause 39, which is as follows, is distinctly thought out for the officers' good:—

“39. With a view to maintain the efficiency of the service, all officers of the rank of lieutenant-colonel and major are placed on the retired list when they have attained the age of 55 years, and all surgeon-generals and colonels when they have attained the age of 60 years. But a lieutenant-colonel who has been specially selected for increased pay, if he attains the age of 55 years before he becomes entitled to the pension for 30 years' service, may be retained until completion of such service; and in any special case where it would appear to be for the good of the service that an officer should continue in employ-

ment he may be so continued, subject in each case to the sanction of the Secretary of State for India in Council."

But the hardship experienced by the officer who enters the Service when he is only a day over 25 years of age is to a large extent unredressed, for he forfeits almost to a certainty his chance of ever reaching a higher pension than £500 per annum. It is an absurdity to invite men into the Service up to the age of 28 years and at the same time to inform them that the maximum pension is not open to them. As a rule, the men who enter the Service after 25 years of age are those who have spent additional time in study at resident hospital posts or in junior teaching appointments in the schools, and such men ought to be encouraged in every way.

The blot in respect of the language examination still remains. No officer, however employed, can receive any staff allowance until he has passed the "lower standard" examination in Hindustani. The hardship of this lies in the impossibility which an officer on first joining the Service may experience in obtaining tuition for an examination that is no longer an absolutely easy one. If his frequent moves do not ruin his studies, he may be allocated to some remote station where he cannot obtain the services of an instructor; and in either case he is precluded for a long time from drawing his proper pay. A young staff corps officer posted to a native regiment receives full pay for one year pending his passing his examination in languages, and the same treatment should be extended to the young officer of the Indian Medical Service.

Turning from the military to the civil side of the Service, we find that the conditions of civil employment are but slightly altered in the new regulations, although three-fifths of the Service are in civil employment. Certain improvements in the pay of the officers in civil employment have received the sanction of the Secretary of State for India, but a surgeon in the Indian Medical Service in civil employment has enormous responsibilities, and the concessions that have recently been made to him are not excessive. He acts as sanitary and medical superintendent of the gaol and its hospital, is surgeon to the police, is responsible for the food of the prisoners, and for the purchase of the raw materials which their labour is to turn out into marketable manufactures. He may have several outlying dispensaries, which he is bound to inspect regularly and which may be four or five days' journey from headquarters, where he also has a dispensary attached to the urban hospital. For the arrangements of his official work and the necessary correspondence he is responsible absolutely. He is assisted only by natives, and he has to make good any deficiency in his accounts. For all this he receives no more than if he were in medical charge of a regiment, although he has applied successfully as a specially gifted man for civil employment. It is no wonder that there is difficulty in getting candidates to pass from the military side into civil employment, while it is certain that if the best work in a service is not the best paid that service will not prove attractive. This fact is now being recognised. Officers in charge of first and second class central gaols, have just had

additions made to their pay, and special rates have been granted to two Inspector-Generals and the Sanitary Commissioners. The military rates of leave pay have been revised and promotion in certain specified conditions has been accelerated. All this has just taken place.

The order that an officer of the Indian Medical Service should refer the question of the amount of his fees, when above a certain low limit, to the civil authority is highly vexatious. No similar proceeding is ordered in any other service in India or elsewhere, and the suggestion that without some such restriction exorbitant fees would be exacted is most unfortunate. This regulation, which has recently been modified but not in a way to remove its sting, points to an official belief that the native, unless protected by the Indian Government, would be exploited by the officers of the Indian Medical Service—a reflection that is felt by many men to be humiliating. It is tantamount to saying that because very large fees have occasionally been received by medical men in India other medical men, unless prevented by the Government, will take unscrupulous steps to obtain a like reward.

The pay of the Director-General of the Indian Medical Service has been increased, as has been said, but his rank remains unaltered. His rank should be increased from that of major-general to that of lieutenant-general, in accordance with the similar concession that has been made to the Director-General of the Army Medical Service; while he should by virtue of his office have a seat on the Viceregal Council, and the surgeon-generals of the

several provinces should similarly sit on the Councils of the Lieutenant-Governors. If medical views could be placed directly before the rulers of the Indian Empire, and if the reasons for medical suggestions could be personally explained to the heads of the legislative machinery, not only would much needless friction be abolished but more efficacious work could be accomplished.

Lastly, something should be done to increase the rates of temporary and permanent half-pay to those who break down in India and are really incapacitated. The rates have now been assimilated to those drawn by officers of the Army Medical Service, but many of the captains in the Indian Service are married, and the rate of permanent half-pay accorded to them is very small.

The Government of India owes, perhaps, more to the Indian Medical Service than to any other department in the country. From the days long ago, when an Indian surgeon obtained a grant of land for the old East India Company from the then reigning Mogul, up to the present time its officers have laboured far and wide in our great dependency for the cause of the Crown. But their recognition has been scanty; and even now that reform has come, it has not come in any complete or satisfactory way.

THE NAVAL MEDICAL SERVICE.

Like the Army Medical Service, the Naval Medical Service, after a respectable measure of popularity with the medical profession for some years, began about 1890 to lose in the eyes of the student the inducements necessary to make him seek a commis-

sion. There grew up a feeling in the medical schools that the career offered in the Service could not possibly terminate in anything but mediocrity. It was true that the naval medical officer saw the world under fine auspices ; that he picked up, or might pick up, a knowledge of nations and languages denied to his civilian brother ; that the work was often not hard, and that the pay could not be described as bad, when the cost of living on shipboard was considered. All that was allowed, but when said there was nothing to add. The opportunities for the study of disease that presented themselves to the naval medical officer could not be used save under substantial disabilities. A surgeon in the navy had no opportunity given him to prosecute scientific research, and was obliged to purchase for himself any instruments that he might require. No encouragement, moreover, was offered to the young medical man who desired to investigate some of the numerous problems in tropical disease that lay unravelled beneath his hands. Time spent in such work probably would not win him the commendation of his seniors, while such commendation, if forthcoming, would be but a barren reward in a service where promotion was governed by seniority rather than selection. The Service as a consequence was depleted by retirement, withdrawal and resignation, and the candidates for admission became fewer. The absolute necessity for study-leave and for increased pay, having regard to the slow advance in rank, became obvious, and grievances in respect to the allotment of cabins and the limited boat privileges, which were of real if minor import, were used to reinforce the claim for reform.

Apart from other considerations the re-organisation of the Army Medical Service under the warrant of 1902 made it imperative on the Admiralty to draw up and to issue fresh regulations for the medical department of the Royal Navy. The new warrants appeared almost simultaneously, and it was at once seen by those who were thinking of the Naval Medical Service as a career that innovations had been introduced of an advantageous character to the medical department. Comparison with previous regulations showed that a great deal could be done under the amended scheme to increase the efficiency of the Naval Medical Service and to improve it generally, while additional inducements could be held out to those who were thinking of becoming candidates for admission into the Service. The framers of the new regulations set about their work in a sincere spirit, the objects aimed at were in the right direction, and the improvements introduced were of a necessary and wholesome kind.

The warrant does not go far enough in some directions, and, as will be seen, leaves undealt with matters that are regarded as serious by the officers of the Naval Medical Service, but in the medical profession generally it should restore a waning confidence. It shows a desire to bring the Service up to the higher standard demanded by the general progress of medicine. The entrance examination has been made of a more practical and clinical nature, better adapted to, and more befitting, candidates already qualified to practise their profession. The subjects are divided into compulsory and voluntary, and the voluntary subjects are selected with a view to secure

men with some knowledge of foreign languages and aptitude for natural science. Provision is reserved for the Admiralty to appoint at its discretion a limited number of candidates from medical schools in the United Kingdom and the Colonies without any competitive entrance examination. Resident medical officers, and house physicians and house surgeons of large civil hospitals can be promoted to the rank of staff surgeon six months or a year earlier than their fellows, and by a later regulation of the Admiralty a successful candidate for a commission is allowed to serve as a hospital resident for a year after entering the Service and to count the time for promotion. An officer can retire after four years' full pay service with a gratuity of £500, and serve in the reserve under conditions which certainly cannot be called onerous.

These changes are intended to insure that those most fully educated and least crammed will be selected for the Service, if a sufficient number of candidates put in their appearance, and thus the principle of selection can be adopted at the very outset of the naval medical career. With the exception of a few specified appliances, a pocket case of instruments, a stethoscope, and three clinical thermometers, all surgical instruments are provided at the public expense. A very important regulation is introduced in regard to courses of instruction, under which medical officers can have practical opportunities and facilities for keeping abreast with the progress of their profession and for studying special branches of it. Every medical officer is now required to undergo a post-graduate course of three months' duration at a metropolitan hospital once in every eight years (should the

exigencies of the Service permit), and this as far as possible during his surgeon's, staff surgeon's and fleet surgeon's period of service. While carrying out this course the medical officer will be borne on a ship's books for full pay and will be granted lodging and provision allowances, and travelling expenses, as for service under the regulations to and from his home or port. He pays the necessary fees for each course himself, but on producing certificates of attendance upon the practice of the hospital and of having taken out courses of operative surgery, bacteriology, ophthalmic surgery, and skiagraphy the Admiralty reimburses him by a grant of £25.

As regards pay and allowances and charge pay all have been improved. The application of the principle of promotion by selection instead of seniority is more fully recognised and encouragement is held out to scientific workers. Promotion is given for "distinguished service or conspicuous professional merit," and such promotions are maintained up to the full number allowed. Officers may get on the list of staff surgeons, *i.e.*, may officially rank with majors in the army, who have not more than four or five years' service as surgeons. Better provision is made for cabins for naval medical officers. Charge pay is no longer reserved for inspector-generals, but is given also to deputy-inspector-generals, fleet surgeons and staff surgeons. The rate of payment is in correspondence with the rank of the offices, being 10s. per diem for an inspector-general, 7s. 6d. for a deputy-inspector-general, 5s. for a fleet surgeon, and 2s. 6d. for a staff surgeon. The Naval Medical Service as a calling compares favourably with the Army Medical

Service in the matter of personal expense. Take, for example, the question of allowances. In the army officers have to maintain lodgings, board, and servant, the latter two items being sometimes expensive, while in the navy an officer has a furnished cabin and a capital mess, for which he pays 2s. a day only, and a servant at a nominal wage, so that from a pecuniary point of view, if a man is careful, the navy is the better service. Charge pay is now received in addition to hospital allowance by all the officers in charge of hospitals or marine infirmaries. All naval medical officers who are in hospitals, dockyards, marine infirmaries, or at the Admiralty receive hospital allowance in addition to charge pay, and any officer not in official quarters receives house allowance also. With regard to full-pay sick leave it is true that the army medical officer is better off, but all naval officers, and not only naval medical officers, suffer in the same way by comparison with the army officers. Under the new warrant a bid has been made for candidates of the best sort for the Naval Medical Service. A man can now fill the coveted junior posts at his hospital and count the time for promotion, he can retire in favourable circumstances if he finds that his bent is more towards civilian practice, and he has opportunities afforded him for scientific work. There is room for criticism, but much progress has taken place. The Admiralty, in fact, has begun to see that a medical officer does not exist only to "doctor people," but that he has functions of the highest importance to discharge in the prevention of disease.

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The various advantages and disadvantages of joining the three Services counterbalance each other fairly, and it must be generally allowed that in each the position for the medical profession is a hopeful one. There are matters that call for revision, but in all three Services the tendency is towards the recognition of scientific merit, while the recent concessions to professional opinion and common sense may be regarded as an earnest for further reform. I would summarise the position as follows: Whereas a few years ago the dean of a medical school who allowed his pupils to enter for commissions to any of the three Services without warning them of possible disappointment, defaulted in his duty; to-day if he recommended a promising young medical man not to compete for a commission he would take upon himself a great responsibility. In all three Services there is increasing scope for the best sort of scientific medical men, and although it is the duty of deans and teachers to be aware of the drawbacks to the Services they should also be acquainted with the movement towards far better things.

CHAPTER VIII

THE COLONIAL MEDICAL SERVICE

The Colonial Appointments: their Anomalies and Contradictions.

—*The Well-organised West African Medical Staff.*

THE duties and responsibilities of the Colonial Medical Service are rapidly increasing with the vastness of the epidemiological fields open to its members. But the establishment is in a muddle. It contains good berths, and often has thoroughly good men to fill them, but it is in course of evolution and presents the inequalities and anomalies arising from its transitional state. The great self-governing colonies, of course, stand in no need of an Imperial service. Canada, Australia and New Zealand, Cape Colony and Natal possess properly-equipped medical schools and hospitals. They, notably the first three, turn out sufficient medical men from the local supply to meet the local wants, while they attract by the freedom of colonial life and the opportunities of private practice a certain number of medical men from the mother country. India is manned by the Indian Medical Service, as well as by highly educated and competent natives, to whom some superior opportunities, though not many, are now allowed for holding appointments. These countries represent the aristocracy of our dependencies, and they have reached a stage of development when they require

no medical service supplied to them from a central government. At the other end of the scale we have countries which are not yet ripe for a civilian medical service, and for whose needs, as far as the men of our own race are concerned, the officers of the Army Medical Service, or the medical men in the pay of pioneering expeditions, must suffice. Certain protectorates, again, as Cyprus and British Borneo, fall under the jurisdiction of the Foreign Office, with whom the responsibility of finding the necessary medical men will rest until the country becomes a Crown Colony. Until this year (1905) Uganda has been in the same position, but on April 1st the jurisdiction over the East Africa Protectorate passed from the Foreign Office to the Colonial Office. Between these two extremes come the countries the medical departments of which are regulated from the Colonial Office. They are:—British Guiana, Jamaica, Trinidad, Tobago, Windward Islands, Leeward Islands, British Honduras, Fiji, Ceylon, Straits Settlements, Federated Malay States, Hong Kong, Mauritius, Seychelles, Gibraltar, St. Helena, Falkland Islands, Gambia, Sierra Leone, the Gold Coast, Lagos, Southern Nigeria, and Northern Nigeria. It is in the West Indies and the West African colonies that medical officers are chiefly required, and the last six of the countries enumerated have been formed into the West African Medical Staff, a definite and properly organised service which can be considered by itself. In the other colonies special conditions attach to service, the leading features of which may be mentioned.

The majority of the West Indian appointments

involve medical charge of a district, including, as a rule, the care of a hospital, poorhouse, asylum, or other institution and free attendance on the aged and children. Passage money is granted to medical officers on first appointment, an annual vacation on full pay is given not exceeding three months in two years, and there are pensions, as a rule, where private practice is not permitted.

British Guiana.—There are 42 appointments. After two years' probation at a salary of £200 per annum, when quarters are provided but private practice is not allowed, the officer is appointed to the permanent staff with a salary of £400 per annum, rising by annual increments to £700. He can carry on private practice and receives a travelling allowance varying with the range of the duties from £100 to £150 per annum. The governor of the colony can also make appointments to the Service in favour of local practitioners who act as supernumeraries upon temporary agreements.

Jamaica.—There are 54 appointments, mainly district appointments with private practice allowed. The salary paid by Government varies from £100 to £250 per annum, and in most cases is £200. Newcomers may be attached temporarily to the public hospital in Kingston, on a salary of £200 per annum, private practice not being allowed.

Trinidad.—In Trinidad there are 32 appointments. After two years' probation at a salary of £250 per annum, with furnished quarters, during which time they are usually attached to the Government hospital, the surgeons obtain district appointments, to which they are promoted as vacancies occur. The pay is

£300 per annum, which is increased to £400 and upwards by various allowances for horse, house, or other purposes. These posts carry the right to private practice. After every five years an officer is given an additional personal allowance at the rate of £50 per annum. In future there will be few appointments in Trinidad, as the Government is aiming at the introduction of a system by which the work shall be performed by private practitioners under temporary contracts. In these three colonies there is a Civil Service Widows' and Orphans' Fund established by law, to which all medical officers must contribute 4 per cent. of their salaries.

Tobago.—In the island of Tobago there are three district appointments, with salaries of £250 per annum, with quarters.

Windward Islands (Grenada, St. Lucia, St. Vincent).—The 22 appointments are, with few exceptions, district appointments with the right to private practice attached. The salaries paid by Government vary from £250 to £400, with allowances in certain cases.

Leeward Islands (Antigua, St. Christopher and Nevis, Dominica, Montserrat, Virgin Islands).—The 25 appointments are of the same nature as in the Windward Islands. The Secretary of State reserves the power to transfer a medical officer from one island to another in each case. The medical officers receive fees for successful vaccinations, post-mortem examinations, attendance and giving evidence at courts of justice, certificates of lunacy, and, in the larger islands, for burial certificates. They are also allowed private practice.

British Honduras.—There are four medical appointments, besides the principal post of colonial surgeon, in all of which private practice is allowed if it does not interfere with the public duties of the officer. The pay varies from £150 to £250. Two of the medical officers are also district commissioners and receive £300 for the combined posts of medical officer and district commissioner.

Fiji.—The medical service has recently been reorganised, and officers appointed in future will be styled Government medical officers and receive a salary of £300, rising by annual increments of £10 to £400. They will be allowed private practice so far as is consistent with the proper discharge of their duty, and will have charge of hospitals or of districts at the discretion of the authorities. The posts will be pensionable, but an allowance in lieu of free quarters will not be pensionable. There will ultimately be 15 Government medical officers in addition to a senior medical officer (who at present receives £450 and £50 allowance for house rent) and a chief medical officer who will have £600 a year. Government medical officers will be given free quarters or an allowance in lieu thereof. This privilege is non-pensionable.

Ceylon.—The pay of 36 sub-assistant colonial surgeons and eight other subordinate medical officers is at the rate of from Rs.900 to Rs.1,600 per annum. There are nine deputy assistant colonial surgeons with salaries at the rate of from Rs.1,500 to Rs.2,500. The 23 assistant colonial surgeons are paid at the rate of from Rs.3,000 to Rs.5,000 per annum, and the six colonial surgeons and three

other superior medical officers at a rate of from Rs. 5,500 to Rs. 8,000 per annum. The principal civil medical officer receives Rs. 15,000, rising by annual increments of Rs. 500 to Rs. 18,000 per annum. As might be inferred from the scale of payment, private practice is allowed to the subordinate officers, but the colonial surgeons may take only consultation practice. The medical service of Ceylon is mainly recruited from persons born on the island but possessing British diplomas.

Straits Settlements.—Two house surgeons in the General Hospital, Singapore, and one in the General Hospital, Penang, receive £300, rising to £360, with free quarters. There are ten other subordinate posts in the medical department with salaries varying from £300 (rising to £360) to £780 (rising to £900). Some of these posts have free quarters attached and the holders of some are allowed private practice within limits. The salary of the principal civil medical officer is £1,000.

Federated Malay States.—There are 18 district surgeons on salaries varying from £480 (rising to £540) to £720 (rising to £840). There are two assistants in the Institute for Medical Research on salaries of from £360 to £420. These posts are non-pensionable and the holders are eligible for appointment as district surgeons. Medical officers have no claim to private practice, which is limited, and the enjoyment of it is strictly subject to the permission of the Government.

Hong Kong.—The principal civil medical officer receives £800 per annum, rising to £1,000. There are two health officers of the port, four medical

officers of health, and four assistant surgeons with salaries of £480 (rising to £720). Most of these appointments are pensionable. Private practice is not allowed and free quarters are only given in a few cases.

Mauritius.—There are 24 medical appointments in all. Of these 14 are minor appointments, with salaries varying from Rs.500 to Rs.1,500 per annum. The other 10 appointments have salaries varying from Rs.2,000 to Rs.9,000. Free quarters are not given in most cases and private practice is not allowed in the best appointments. The service is mainly recruited from persons born on the island. Officers in the service of Mauritius are required annually to contribute 2 per cent. of their salaries towards their pensions.

Seychelles.—There are four medical appointments. The Government medical officer receives Rs.4,000. The assistant Government medical officers receive Rs.3,000. The holders of these latter appointments have free quarters. Private practice is allowed.

Gibraltar.—There is a surgeon to the Colonial Hospital receiving £275 and an assistant surgeon receiving £96, in each case with quarters, fuel and light allowance, and permission for private practice. The surgeon of the hospital, as medical officer of the civil prison and lunatic asylum, receives £55 and horse allowance of £42. The assistant surgeon is also public vaccinator, police surgeon, for which he is paid £45, and port surgeon, for which he receives £109.

St. Helena.—The colonial surgeon receives £300 per annum and £30 horse allowance. Private practice is allowed.

Falkland Islands.—There are two appointments, one of which is paid at the rate of £300 per annum, with £25 as health officer, and the other at the rate of £200 per annum. Private practice is allowed in both cases.

Cyprus.—There is a chief medical officer paid at the rate of £500 per annum, two district medical officers paid at the rate of £250 per annum, and one paid at the rate of £200, rising by £10 a year to £250, all enjoying private practice, and receiving 2s. per diem forage allowance. These are the only medical appointments in the island which are open to English candidates, and they are made by the Foreign Office.

All applicants for medical employment in these eighteen colonies must be between the ages of 23 and 30 years, and must be qualified for registration. Preference will be given to those who have held appointments as house physicians and house surgeons, certificates of moral character and of sobriety will be required, and every officer before being appointed will be medically examined by one of the consulting physicians of the Colonial Office. There are pension funds established for widows and orphans in Ceylon, Straits Settlements, the Federated Malay States, Hong Kong and Mauritius, to which all permanent Government servants must subscribe 4 per cent. of their salaries.

British South Africa.—Cape Colony and Natal are, as has been said, self-supporting colonies, but other districts in South Africa need the help of the central Government. Medical appointments in the Bechuanaland Protectorate and Basutoland are made

only on the recommendation of the High Commissioner of South Africa, who usually appoints local candidates. Appointments of medical officers to the South African Constabulary are also made by the High Commissioner on the recommendation of the Inspector-General. Medical appointments in the Transvaal and Orange River Colony are only made on the recommendation of the governor of those colonies. Rhodesia is administered by the British South Africa Company, the High Commissioner having a control over legislation. There are a certain number of medical appointments in Southern Rhodesia, at Salisbury, Buluwayo, and other townships, which are in the hands of the Administrator of Rhodesia. The terms of contract between the British South Africa Company and the surgeons, do not always give satisfaction.

The anomalies and contradictions implied in these notes upon the Colonial Medical Service hardly require to be pointed out. Salaries differ with no apparent difference in work or responsibility. In some places there is a widows' and orphans' fund, in others there is not, and where it exists the deducted percentages are not uniform. Here private practice is allowed and here it is not, or at any rate specific permission is omitted. In some places the officers are largely recruited from the native-born, who are given the better berths, and in others they do not seem to be taken into consideration. There are no settled rules about pensions, allowances, or extra fees. Titles are given at haphazard; one man is called "Principal Civil Medical Officer" and another "Chief Medical

Officer." It might be guessed that they hold the same rank, but a "Government Medical Officer," a "Colonial Surgeon," and a "District Surgeon" are not obviously interchangeable characters. There are no provisions for promotion which entail that the headship of the medical department in a colony will be obtained by a member of the medical staff of the colony, so that men may be suddenly disappointed in their hopes of securing berths which had seemed well within their grasp. When it is remembered that some appointments are made by the Foreign Office, some by the Colonial Office, some by colonial governors, and others by trading companies, it will be seen that it is no overstatement to allude to the establishment as being "in a muddle."

THE WEST AFRICAN MEDICAL STAFF.

We now come to that branch of the colonial medical service which is a properly organised entity. The medical services of the West African colonies and protectorates—viz., Gambia, Sierra Leone, the Gold Coast, Lagos, Southern Nigeria, and Northern Nigeria—form one service, the West African Medical Staff. All the medical officers for this Service are selected by the Secretary of State for the Colonies. They are engaged in the first instance for one year on probation and, except the principal medical officers, are allowed to engage in private practice as long as it does not interfere with the efficient discharge of their official duties. There are fair allowances when junior officers discharge the work of their seniors by deputy. Stores are transported free, out-of-pocket expenses in travelling are recoverable,

there are proper horse, field, and outfit allowances, and all medical men are paid 10s. per diem extra with free rations, or 3s. in lieu of rations, while serving on military expeditions. Candidates for the West African Medical Service must be British subjects of European parentage, preferably unmarried, and between the ages of 25 and 35 years. They may choose their colony or protectorate, and as far as possible their wishes will be met, but they must make up their minds carefully as transfers are seldom made.

The grades and salaries of medical officers are shown in the following table:—

Grades.	Gold Coast, Southern Nigeria, Northern Nigeria.			Sierra Leone, Lagos.			Gambia.		
	Minimum salary.	Annual increment.	Maximum salary.	Minimum salary.	Annual increment.	Maximum salary.	Minimum salary.	Annual increment.	Maximum salary.
Principal medical officer	£ 1000	£ 50	£ 1200	£ 800	£ 50	£ 1000	£ —	£ —	£ —
Deputy principal medical officer	700	25	800	—	—	—	—	—	—
Senior medical officers	600	20	700	600	20	700	500	20	600
Medical officers	400	20	500	400	20	500	400	20	500

Every candidate selected for appointment will, unless the Secretary of State decides otherwise, be required to undergo a course of instruction for two or three months at the London School of Tropical Medicine or at the Liverpool School of Tropical Medicine. If for any reason he does not undergo the course before appointment he will be required to take out instruction on less favourable pecuniary terms

during his first leave of absence. The cost of the tuition, fees, board, and residence during such instruction, amounting to a maximum of £48 8s. 10*d.* for three months, will be borne by the Government, and a daily allowance of 5s. will be paid to each candidate during the course, and may be continued subsequently up to the date of embarkation. These payments will be made subject to the candidate signing an agreement by which he will be bound to refund them (1) if he declines to accept an appointment in any of the colonies or protectorates for which he may be selected ; (2) if he fails to obtain a proper certificate of proficiency from one or other School of Tropical Medicine ; or (3) if he relinquishes the West African service for any other reason than mental or physical infirmity or is removed for misconduct within three years of the date of his arrival in West Africa.

The arrangements for special allowances and leave of absence are fair. The ordinary term of residential service is one year, followed by leave with full pay during the voyages to and from England and for four or two months clear in England, according as the officer is returning for further service in West Africa or not. If an officer is detained beyond the year additional leave is given with full pay for ten days in respect of each completed month beyond 12, whether he is returning or not. If he is invalided before the end of the year the leave with full pay is for the voyages and for ten or five days in respect of each completed month, according as he is returning or not. Leave granted on the understanding that an officer will return is known as "return leave," and any pay

drawn in respect of such leave is liable to be refunded if an officer does not return. Leave may be extended for a limited period with half or no pay on the ground of ill-health, or without pay on other grounds. Free passages are given to all officers who are granted leave, and on first appointment. On attaining the age of 50 years, or after 18 years' service (of which at least 12 must have been residential) an officer is qualified for a pension calculated at one-fortieth of the last annual salary for each year of service. If invalided after a minimum of seven years' service he is qualified for a pension calculated at the same rate. If invalided before completing seven years' service he is qualified for a gratuity not exceeding three-fourths of a month's salary for each six months of service, provided that he has been confirmed in his appointment and that he is specially recommended by the governor or high commissioner for such gratuity. At the end of nine years (of which not less than six must have been residential) an officer of the West African Medical Staff is permitted to retire with a gratuity of £1,000, or at the end of 12 years (of which not less than eight must have been residential), with a gratuity of £1,250, such gratuities being in lieu of pension.

The successful organisation of the West African Medical Service makes it a practical question to ask why the Colonial Medical Service of the Empire should not be organised on similar lines. The Service, as a whole, has grown up gradually and has developed with the growth of the empire into a conglomeration of elements that require rearrangement. It should be placed on a basis similar

to that of the Army or Indian Medical Services though avoiding the blemishes in these schemes. The age of the candidates should be made uniform, and probably it would be advantageous to admit no one over 28 years of age. There must be hesitation in recommending that entrance should be by a competitive examination, because the multiplicity of examinations is already the bane of the young medical man's life, but an examination in hygiene and tropical medicine should be strict, compulsory, and competitive to this extent that future appointments should in some measure be made to depend upon how a candidate has acquitted himself at this test. All gradation of rank and title should be definitely settled ; pay and allowances should be equalised in accordance with such a scheme and in accordance also with the marked unhealthiness of certain districts. The whole Service should be a definite department of the Colonial Office ; the position of the Foreign Office in having certain appointments to give away in the Colonial Medical Service forms a ridiculous and unnecessary complication, while the powers at present given to colonial governors are as often as not used wrongly. It may be asked : Who knows local conditions better than the local man ? The answer to this is that special men should certainly be appointed in special circumstances by the colonial governor. But if the Colonial Medical Service is to be organised into strength, the privilege of the governors should be sparingly used. For the filling up of good berths by local men must have a bad effect on the Service as a whole, because it militates against recruiting in the

mother country. Save in peculiar circumstances and with permission of the Colonial Office it would be advisable for all appointments to be filled by the promotion of men in the Service. And when outsiders are given berths the appointments should be temporary and supernumerary, although they should be well paid ; indeed, they should be exceptionally well paid because they should only be made in exceptional circumstances.

CHAPTER IX

THE SANITARY SERVICE

The Sanitary Service in England and Wales.—County and Borough Medical Officers.—The Medical Officer of Health in Private Practice.—Insecurity of Tenure.—Suggestions for Reform.—The Sanitary Service in Scotland.—Security of Tenure.—The Absence of a Sanitary Service in Ireland.

THE sanitary services in England (including Wales), Ireland, and Scotland are on entirely different bases and offer consequently different advantages counterbalanced by different drawbacks. Organisation has been carried to further lengths in England than in the other countries, because a large number of English populous centres are able to support an officer who gives his whole time to the care of the public health of the community. The great modern problems of overcrowding and of housing the poor have been more pressing in England than elsewhere and in consequence the necessity of the exclusive services of a sanitary expert has been more quickly recognised.

THE SANITARY SERVICE IN ENGLAND AND WALES.

The position of the medical officer of health is well defined although anomalous. By the Public Health Act 1875, every urban and rural sanitary authority in England is required to appoint a medical

officer of health and an inspector of nuisances ; but two or more districts may be combined by the Local Government Board to form a combined sanitary district, with one set of officers for the whole combination. The medical officer of health may be paid entirely by the community out of the rates or the help of the Local Government Board may be sought. If any part of the salary of a medical officer of health is paid by the county council on the certificates of the Local Government Board that Board exercises power of approval over the appointments, duties, and tenure of office of the officer, but it has to be noted that the duties of medical officers of health as prescribed by the Local Government Board are identical whether or not any contribution to salary is made out of county funds. County councils, under the Local Government Act 1888, may appoint a county medical officer of health. These officers may either be required to give all their time to their appointments, which are generally well paid (though the remuneration is not too large when the responsibilities of the post are taken into account), or they may be engaged merely at a nominal fee to give advice when it is sought and to summarise the reports of the district medical officers of health. It is optional for county councils to make such appointments and at first sight we might expect the tendency to be against them. For it must be remembered that the large towns in England all have medical officers of health who, for the most part, are occupied solely with the sanitary needs of the towns, so that it is the country side that is chiefly concerned in the appointment of a medical officer of health to assist

the county councils in their deliberations. Now the country side is feeling the stress of hard times in England, competition and the rate of wages having put large tracts of land out of cultivation, and county councils might have been held justified in avoiding all possible charges upon the county rates. But county councils have proved themselves awake to the value of having a county medical officer of health, and although progress is somewhat slow the majority of our counties are now provided either with a whole-time or a consultant medical officer of health. The economy of prevention is recognised, while the concentration of many minor appointments among rural districts into one well-paid appointment becomes feasible where the general superintendence of a county medical officer is forthcoming.

The medical officers of health to the different sanitary constituencies of England may, like the county medical officers, be divided at once into those whose sanitary work occupies all their time—whole-time officers, and those who combine the duties of medical officer of health with those of a general practitioner—half-time officers. Nearly every large town of importance in England now possesses a medical officer of health whose duties as such form his only occupation, and for the last twelve years it has been incumbent upon a candidate for these posts, where a city or district having at the last census 50,000 inhabitants is concerned, to possess either a diploma in public health or credentials pointing to special sanitary experience. The duties of the whole-time medical officer of health in a large town are onerous, responsible, and delicate, and as a rule the salary is not a

generous one, ranging from £500 to £1,000 per annum, though in a few important instances the salary is higher. But there is nevertheless strenuous competition for the posts, so that the public may be pardoned for thinking that a rather low scale of payment is counterbalanced by agreeable features in the appointments. And certainly the life of a medical officer of health in a large town, if he has the ear of the authorities, is a pleasant one. He has great power, if he will use it with tact and discretion, and enormous responsibility, and the stand-up struggle against disease that he is called upon to wage cannot fail to be exhilarating to the man with a medical soul. He is free from the worries and responsibilities of practice but in touch with the larger aspects of medicine. His work is very hard, and he does not receive that personal meed of gratitude that falls to the lot of private practitioners, but neither has he to submit to the whims of unreasonable individuals unless his authority should chance to be unfortunately constituted.

Many urban and most rural sanitary constituencies in England cannot support a medical officer of health solely to discharge sanitary duties. The work might in some instances easily be found for him to do, but the community could not afford the salary. As a consequence in many rural districts the medical officer of health is a general practitioner, who receives from the authorities a small salary to perform duties which, however light they may be as a rule, can at any moment become of overwhelming importance. The special difficulty of these appointments is that the public duties and private interests of the medical

officer of health may clash,—a situation in which no man should be placed. A certain sort of house-owner, for example, is known to resent bitterly the interference by the medical officer of health with his private property. If he is put to the expense of bringing his property into sanitary condition he will bear a grudge against the medical officer of health, which in some cases he is able to gratify. Where the medical officer of health is not in private practice he can disregard such behaviour, but when his livelihood depends upon the goodwill of the neighbourhood it is difficult to sit down under slander. I may seem to have put an extreme case, but it is well known that where the medical man is in private practice members of the public bring pressure to bear upon him in his official capacity, and if he does not respond as they desire unworthy individuals endeavour to punish him.

The curious character of the appointments of the medical officer of health can hardly escape attention. He is the servant of what is in effect a form of partnership between the central authority, viz. the Local Government Board representing the whole country, and the sanitary authority representing local interests. He works under the Local Government Board, without the sanction of which he cannot be appointed save in the rare instances when the sanitary authority has not asked for any State subsidy, but he may be dismissed from office by the sanitary authority even when carrying out the recommendations of the Local Government Board. If any suggestion of the medical officer of health involves expenditure of money, and if his local masters, either from genuine economy

(founded perhaps upon an innocence of hygienic knowledge) or from a desire to make a show of economy (to cover perhaps their own mistakes) do not think fit to spend the money, the suggestion of the medical officer will be ignored, whatever the public consequences may be. Then if the medical officer continues to make inconvenient proposals, so that pressure is brought to bear upon the authority by the Local Government Board, the medical officer may fail to secure re-election. He is certain so to fail if his authority is much impressed with its own personal importance, and is also behind the times in scientific knowledge. Here is a story in point, and many others could be supplied. A medical officer of health had held office in a rural district, with a population of 16,000, for 16 years, and had been re-elected every three years. The district council passed a resolution requiring him to visit every case of infectious disease which was notified and to make a special detailed report thereon. In connection with this resolution a communication was received by the district council from the Local Government Board pointing out that it was usually undesirable for the medical officer of health to make a personal diagnosis of infectious cases notified to him, and that in the instances where personal inspection might be needful the co-operation of the medical practitioner having charge of the patient should be sought. Having this definite expression of opinion in view the medical officer of health wrote to the district council, saying that he could not in future give the detailed reports required. Whereupon the clerk to the council was directed to write to him asking him to resign his office unless he

carried out the "lawful orders" of the council. We could not want a clearer instance of the impossibility of serving two masters; and it would be easy to quote others showing that, when an authority is ignorant or corrupt or prejudiced, a medical officer of health can only obtain fixity of tenure upon sufferance, and that sufferance is usually granted as a recognition of inaction. This is a highly discreditable position of affairs, and one that calls for immediate rectification.

The medical officers of health in London are not appointed for any specified limit of time and are only removable by the authority with the consent of the Local Government Board. Some such measure of security ought to be enjoyed by all medical officers of health, but fixity of tenure for medical officers of health must not be regarded as the one and complete answer for every fault in the sanitary administration of the country. The aggregation of many separate sanitary areas into combined districts, with a development of administrative work on the part of the county medical officer, is the direction, probably, towards which reform will tend in England and Wales. This is not the same thing as a universal fixity of tenure in sanitary appointments, for which the country is barely ripe.

Nor again is a panacea to be found for ills that certainly exist in the formation of combined districts under whole-time officers. The scheme may look well on paper but it would not necessarily work smoothly. The distances such an officer would have to travel are great, allowances for expenses would lead to endless trouble, and an outbreak of infectious

disease in a distant part of his jurisdiction might mean a considerable sum out of the pocket of the medical officer of health, as well as the enforced neglect of his other duties. The best system, at any rate at the present time, would probably be to continue whole-time medical officers of health in the large towns, but in small towns and rural districts to have local practitioners with district medical inspectors appointed by the Local Government Board. The local practitioner chosen for the post should be one taking an interest in sanitary affairs and for preference one who possesses a diploma in Public Health. If county medical officers, assisted by inspectors on the same lines as the existing Poor Law inspectors, would visit periodically the half-time medical officer of health, and would occasionally attend meetings of the district councils, many distinct advantages would ensue. The inspector would be able to support the proposals of the medical officers of health and to indicate what conditions require to be remedied and in what way. The Local Government Board would thus come into closer touch with the sanitary administration of the country than it is at present. For now, unless there is some conspicuous outbreak of fever leading to a visit from one of the medical inspectors of the Board, the report of the medical officer of health is the only link between the district council and the Board. The Board has no means of knowing whether the district councils are properly administering the Public Health Acts. Recently the Local Government Board took the initiative in recommending to a sanitary authority in Wales that the medical officer of health should be

appointed for an indefinite term instead of for two years and the authority very properly fell in with the recommendation. This is apparently the tendency of the Board in all cases where the officer has a satisfactory record with the central authority. But some extended method is wanted by which the Local Government Board can become acquainted with the scientific and personal qualities of the medical officers of health. If the Board, being kept well informed by their medical inspectors and the county medical officers, would pursue this policy of instructing sanitary authorities how to treat the medical officer of health so as to secure his best work, the sanitary service of England and Wales would be much improved, fixity of tenure would be insured to the men whom it is in everybody's best interests to keep in their offices, while inactivity would not secure re-election to a post.

THE SANITARY SERVICE IN SCOTLAND.

The Scottish system of sanitary service is the best in the United Kingdom, but it requires a little explanation for its exact understanding.

In Scotland all medical officers of health, by whatever local authority they are appointed, have security of tenure under Section 54 (4) of the Local Government (Scotland) Act, 1889, which is as follows: "Every medical officer and every sanitary inspector appointed under this Act or under the Public Health Acts, shall be removable from office only with the sanction of the Board of Supervision." (The "Board of Supervision" was the precursor of the Local Government Board.) Every burgh and every county

council appoints its own medical officer of health. The medical officers appointed by the burghs act only within the burghs. Those appointed by the county council have charge of all the rest of the county—that is, practically, all the rural districts, though in some lowland counties there are a number of populous places that are not burghs, and the county medical officers have charge of these. Under the Public Health (Scotland) Act 1897 (Section 15) it is essential for every medical officer of health appointed since the Act came into force to be registered “as the holder of a diploma in sanitary science, public health, or State medicine.” This provision is not retrospective, but in many small burghs there is no medical man with a qualification in public health, and when the medical officer of such a burgh dies or resigns the result not infrequently is that the county medical officer is appointed, so that the influence and sphere of work of the professed sanitarian tend to increase.

The duties of a county medical officer are not the same in Scotland as in England. In Scotland he is the executive and administrative officer. He is so not because he is county medical officer, but because every county medical officer is also medical officer for the districts under the charge of the district committees of the county councils. These district committees themselves are the local authorities under the Public Health Act, and when a man is appointed county medical officer he is also appointed medical officer for the districts of the county, these districts not including the burghs. Each district committee consists of the members of the county

council resident in that district and also of a representative from each parish council in the district. The police burghs have representatives on the county councils, and also therefore on the district committees, but they do not act in public health matters as the burghs are not rated for public health by the county council, each burgh having charge of its own public health. As already stated, however, the county and district medical officer may hold burghal appointments also, but the custom is that the larger burghs have their own medical officers.

It is compulsory on every county to have a medical officer of health, and the appointments are permanent in the sense already explained. Nearly all the county medical officers are whole-time officers. In the largest burghs also the medical officers are not in general practice, but several of them hold other appointments more or less related to public health. In the smaller burghs the medical officers are usually engaged in private practice unless it should occur that the county medical officer holds the appointment. This is a position which tends to occur more frequently and is of good omen, as it implies a general improvement in salary, for the range of salaries in Scotland, although it is improving, is not so good as it is in England. The areas controlled by the district committees of the Scottish county councils are in most cases sufficiently large to prevent local influences having sway, especially as the medical officers are not engaged in private practice and have security of tenure over fixed areas. The smaller burghs are the worst off on the whole, because their areas are limited and local influences

consequently have more weight. Their medical officers have of necessity only small salaries, so that a mere fraction of their income represents their public work and their private practice is of supreme consequence to them. Everything that has already been said about the undertaking by English medical officers of health in rural districts of both public and private duties can be said concerning the Scottish medical officer of health when doubly employed, but the northerners have the best of the situation. They cannot be dismissed excepting with the approval of the Local Government Board. That Board has control of the distribution of a government grant towards the salaries of medical officers of health and sanitary inspectors. It has power to refuse the grant if local arrangements are unsatisfactory. At present the grant, which is a fixed sum of £15,000 per annum, contributes about 7*s.* 6*d.* per £ to salaries and travelling expenses. The salaries for whole-time medical officers range from about £350 or £400 to about £850, exclusive of travelling expenses and other outlays.

THE SANITARY SERVICE IN IRELAND.

In Ireland the dispensary medical officer, whose position will shortly be described, in addition to all his other work, is the medical officer of health of the district. The Irish local board of guardians, which elects him as a medical officer, corresponds in certain of its functions to the urban and rural district councils of the English local government scheme, and the dispensary medical officer is the executive sanitary official. In the smaller towns and in the rural

districts the whole sanitary organisation of Ireland is a farce. The dispensary medical officers are hopelessly underpaid and overworked. It is quite impossible for many of them to perform adequately the part of their duties that is represented by attending at the dispensaries and making visits at the patients' houses—and wretched houses some of them are. If the dispensary medical officers give up the whole of their time to their functions as poor-law medical officers (and most of them do so) it is clear that they have no time to attend to their private patients. And yet, unless they can get private practice and supplement their salaries by certain little subsidiary appointments, they cannot make a livelihood. How are men, worked in this manner to the limit of their power for the lowest wage, to find time to take sanitary charge of great areas for the most part inhabited by a poor and ill-educated population? The need in Ireland is very great of county medical officers of health, properly salaried, and debarred from medical practice, who might travel from place to place, inaugurate a scheme for general sanitary improvement, and see it carried through. At present the sanitary system of Ireland does not exist.

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It will be seen that the sanitary services in the three countries have certain points in common. Where the country side is sparsely populated and the districts are poor, no funds for the payment of a medical officer of health are available. It is true that such districts escape risks which have to be taken by more crowded communities, but it is none the less dangerous that they should be left without

proper sanitary inspection and control. In Ireland this ineffectiveness of the sanitary administration is only part of the deplorable condition of the dispensary medical service, and the remedies to be taken for the abuses are the remedies which should be applied to the reform of that service, which will be suggested in dealing with the administration of the poor-law in the three countries. In England we have a much more crowded country with a much higher general standard of wealth. There is no reason, in theory, why England should not have a capable and fearless sanitary administration, but in practice the law is against it. In which attitude the law is also against much public and official opinion. When Sir Walter Foster was Parliamentary Secretary to the Local Government Board, now nine years ago, he spoke as follows to a deputation that had represented to him the inconvenience of placing the medical officer of health in a position where he is at the mercy of ignorant caprice:—

“The Board has arrived at a rather important decision, viz., that we consider these appointments for short periods and precarious tenure injurious to the public health. We are at one with you that men holding appointments for very limited periods cannot be expected to discharge their duties in that fearless and thorough manner which those duties require for the safety of the public, and we are anxious to encourage local authorities to give up the system of short appointments. We recognise that these offices are very delicate and difficult, as well as exceedingly responsible, and while a man is elected from year to year by a sanitary authority who may

be offended by his zeal for the public health, we feel he cannot discharge his duties in the way they ought to be discharged. We have, therefore, arrived at the decision that we shall encourage local authorities all over the country to make these appointments for longer periods and, if possible, permanent appointments."

These be brave words, but as yet they remain largely words. The Local Government Board has done something towards their fulfilment and is still doing something; but reform comes very slowly. Fixity of tenure is more likely to follow upon the general appointment of county medical officers than upon the recommendation of the Local Government Board to certain authorities that certain individual medical officers of health should not have a term set to their period of office.

CHAPTER X

THE POOR-LAW MEDICAL SERVICE

The Poor-law Medical Service in England.—Long-standing Abuses. —The Poor-law Medical Service in Scotland.—The Case of Mr. Lamont. — Parish Councils and Arbitrary Dismissals. — The Scottish Poor-law Medical Association.—The Poor-law Medical Service in Ireland.—The Death of Mr. William Smyth, of Dungloe.—The Grievances of the Irish Dispensary Service.—The Absolutely Necessary Reforms.

THE poor-law medical services of England, Scotland, and Ireland, like the sanitary services of the three countries, are on different bases, and with respect to the two last-named countries the abuses that are to be found in their working are gross. The grievances of the English service run a risk of being overlooked because they are of a less sensational character. They are none the less real.

THE POOR-LAW MEDICAL SERVICE IN ENGLAND.

The poor-law medical officers in England are not oppressed by Bumbledom to any grave extent, and their position is a fairly independent one. Still they are not without legitimate causes of complaint. The salaries of the medical officers to the poor-law infirmaries are small and their exiguity is not counter-balanced by opportunities for private practice. The life is dull and a large proportion of the

clinical material presents no features of interest to scientific medicine, though this is a state of things which is tending to improve. The salaries of parochial officers are also small, but they are punctually paid. The fact that the poor-law officer is, as a rule, the social superior of the guardians under whom he serves now and again results in annoyances, but a hard-working and tactful practitioner escapes most of the unpleasantness, and the competition for the posts shows that they have distinct attraction. The explanation of this is probably that in some places the possession of poor-law appointments brings compensating advantages in practice, a view that is strongly combated by those to whom no such advantages have accrued, and who contend that the more substantial class of patients have an objection to employ the "parish doctor." Wherever in the social scheme we get competition for posts and complaints of inadequate remuneration going together there will be a difference of opinion as to the reason of such an apparent violation of the laws of supply and demand, and the fact that many desire to fill the berths will be employed as an argument to close the mouths of those who would assert that the berths are not worth filling. As a matter of fact, in the case of the poor-law medical officer no general rule applies, as the scale of pecuniary return is not uniform, and the attitude of the public and the poor-law guardians is not the same all over the country.

It is an undoubted hardship upon poor-law medical officers that in many instances the salaries remain the same as they were forty years ago, in spite of the

largely increased cost of living generally, and of medical education and medical practice in particular. All medical men in general practice are suffering from the fact that their professional fees have remained for the most part stationary while everything incidental to medical education and practice has gone up in price, but poor-law medical officers have an easily demonstrable claim upon the public for better terms. The special fees for operations were fixed in 1847, and have not been revised since. There are numerous operations, the outcome of advancing surgical knowledge, for which no special allowance can be obtained without the consent of the guardians, and there is no fee provided by law for giving anæsthetics. As far back as July 1902, the President of the Local Government Board was asked in the House of Commons to explain why no provision was made for the administration of anæsthetics when operations had to be performed by poor-law medical officers on sick paupers at a distance from a hospital or workhouse infirmary; and why no alteration had been made in the scale of fees allowed for special operations performed by poor-law medical officers since the year 1847, many important operations, which have now become general, not having been placed on the statutory list. The President of the Local Government Board (at that time Mr. Long) replied that the Board recommended that in ordinary circumstances a case in which a serious operation was required should not be treated in a workhouse or at the patient's home, but should be sent to a public hospital. This was the position taken up by the Board eight years previously in a

circular letter issued to all boards of guardians, though in that letter it was stated that in any case, when it was not practicable to send the patient to the hospital, and when the operation was not of a serious character, the guardians might sanction the payment to the medical officer of a reasonable sum in respect of any assistance which it was necessary for him to obtain for the administration of an anæsthetic. Mr. Long went on to point out that it had been the invariable practice of the Board to give its sanction to reasonable payments proposed to be made by boards of guardians to medical officers in circumstances of the kind referred to, and added that he was unaware that difficulties had been experienced in connection with the scale of fees to poor-law medical officers for operations, but that if representations were made to him showing alterations to be required he would give the subject careful consideration. How Mr. Long came to be unaware of the dissatisfaction among poor-law officers at the scale of fees for operations is difficult to understand, but during his tenure of office as President of the Local Government Board he proved himself in many ways an enlightened advocate of medicine, and we may feel certain that his want of information was real and not merely official. With his opinion that in ordinary circumstances patients requiring serious operations should not be treated in their homes all medical men are in agreement; it is not so certain that the recommendation to draft every important surgical case to a hospital in contradistinction to an infirmary is so sound. But the promise of careful consideration of the whole subject has not been kept

by the Local Government Board. In December 1902, encouraged by Mr. Long's kind words, the English Poor Law Medical Officers' Association addressed a memorial to the Local Government Board pointing out that in spite of the Local Government Board's circular letter of 1894 guardians almost invariably declined to ask the sanction of the Board for the payment to medical men of fees for extra services, so that the poor-law medical officer, when requiring to perform an operation upon a pauper patient, has either to obtain the unpaid assistance of a brother practitioner or to pay the anæsthetist's fee out of his own pocket. The memorial suggested that a fee of £1 should be paid for the administration of an anæsthetic, the payment being restricted, if thought well, to those instances where a certificate of its necessity is forthcoming from a second medical practitioner; while operations, now common procedures, like laryngotomy and tracheotomy, should be paid for at the rate of £2, the statutory fee for such operations as amputation of fingers or toes. The highest payment for operations on the present scale to poor-law medical officers of health is £5, which is the fee for the treatment of strangulated hernia, of compound fractures or dislocations of the thigh or leg, and for major amputations. To this list the memorial proposed to add the operation of trephining and the treatment of a compound fracture of the patella; while for simple fracture of the patella a fee of £3 was asked. The memorial acquiesced in the general proposition that serious cases should be treated as far as possible in a hospital, but dwelt upon the difficulties of poor-law medical officers in

country districts where it may be often impossible to move a patient to a hospital. In such cases the particular injustice done to the poor-law medical officers, in making them attend the patients without extra fees, is aggravated by the fact that many hospitals receive from boards of guardians payments for the reception of cases for operation—the scale of which payments, by the way, might well be scrutinised. To this memorial the Poor-law Medical Officers' Association has received no reply, in spite of Mr. Long's sympathetic words in Parliament, and official neglect must necessarily confirm boards of guardians in their intention not to take any steps to grant extra fees.

The attitude of boards of guardians towards their medical officers differs considerably—in some districts the work is harmoniously carried on and in others it is not. In certain parts of the country boards of guardians have refused to raise the salaries of their medical officers, being public vaccinators, on the plea that the last Vaccination Act has increased the public vaccinator's fees, and some guardians have been attempting, where contracts have terminated, to reduce salaries on the same grounds. This is, of course, quite unfair. To begin with, any reduction of the salaries of poor-law medical officers must be illogical considering the increasing work that now has to be done by them and the enhanced expenses of medical education and medical practice. In the second place, the emoluments received by public vaccinators, who are also district medical officers, vary so much that no general conclusions can be drawn from them. In some urban districts the

public vaccinator's fees may pay him well, in some rural districts they certainly do not. But in urban and rural districts alike, a request by medical officers for a higher salary, based upon an increase of work and an increase of expenses, is generally met with a refusal at the hands of the guardians, who quote in support of their action the vaccination fees.

Thus it will be seen that the grievances of the poor-law medical officers in England are quite genuine, if not exactly glaring as they are in Scotland and Ireland. Their work has increased and their expenses have increased, while their salaries have remained the same, not without threats of curtailment. Yet there is considerable competition for the posts, so much that favouritism, it is alleged, takes place in respect of the appointments. How is this to be explained? Firstly, the pay offered by the unions, poor as it is, is better than that offered by medical aid associations. Secondly, the posts sometimes carry indirect advantages. It seems impossible to escape from the conclusion that these posts are accepted in certain instances because they provide the holders with a publicly guaranteed introduction to the neighbourhood.

THE POOR-LAW MEDICAL SERVICE IN SCOTLAND.

In Scotland the public medical service, the service which is intended to meet the wants of the indigent poor, is in urgent need of reform. Attention was called in 1899 to the scandalous condition of affairs by the *cause célèbre* of Mr. J. Lamont, the medical officer of South Uist, whose vicious treatment by the authority to whom he owed his appointment was

made the subject of Parliamentary interference. Mr. Lamont was dismissed summarily from his office by the parochial authority, his dismissal being apparently due, at least to a great extent, to his insistence on the closure of a school during an epidemic of infectious disease. In this he had the support of the Local Government Board of Scotland, but that availed nothing when, as a practical rejoinder, the parish council terminated his appointment. Following on his dismissal from office Mr. Lamont's oppressors in South Uist raked up the fact that he had some considerable time before vaccinated certain children, whom, owing to press of work, he had certified as successfully vaccinated without paying a second visit, his certificates being based on what he regarded as trustworthy information. This he did in his inexperience and in the absence of official guidance as to his procedure; but it appears that the practice is by no means unknown in the northern counties of Scotland. It is an evil practice and no one should attempt to justify it; but the prosecution of Mr. Lamont was undertaken in a manner warranting the theory that its origin was to be sought, not in regard for the law or in zeal for vaccination, but in vindictive spite. It was the manner in which Mr. Lamont was treated that led to the publicity which may yet have a fortunate issue, as it has called attention to the grievances of the poor-law medical service of Scotland, especially of those whose duties lie in the highlands and islands. Mr. Lamont was arrested at midnight in his mother's house on the allegation that he had absconded from justice, he was imprisoned for two days, was escorted from

Glasgow to South Uist by the police, was imprisoned a second time, and on release was subjected to a fresh warrant of arrest in London. The nature of this persecution led to very downright speaking upon the existing conditions of the Scotch poor-law medical service in the press. Then came action in Parliament. Sir Charles Cameron, in Committee of Supply, on the vote for the salaries and expenses of the office of Secretary for Scotland, called attention to the case, and, when the Lord Advocate defended the prosecution as right and justifiable upon the evidence, several influential Members of Parliament spoke in strong criticism of this view, asserting that Mr. Lamont had been harshly used and was entitled to some sort of compensation. The Lord Advocate then agreed that the arrest should not have been ordered and undertook to censure the Procurator-Fiscal, when the Prime Minister delivered an important pronouncement. He expressed his regret that in the present state of the law medical officers in Scotland had no protection against the action of the local authorities, and thought that the Government ought to possess the power to protect medical officers whose duties must occasionally bring them into collision with, and subject them to the arbitrary action of, those who were their employers, and against whom at the same time it might be their duty to proceed. He pointed out that as the law stood no •Vote in Supply could effect the matter at issue one way or another, directly or indirectly, but he discussed the question whether any action could be taken against the local authorities, who, it appeared from the discussion, were the real villains of the

piece. The Lord Advocate at the close of the discussion announced that he had the authority of the Prime Minister to say that he considered himself bound to look into the question of compensation.

Mr. Balfour's words raised all the issues admirably because he so clearly distinguished between the great grievances of Mr. Lamont and the anomalous position of all poor-law medical officers in Scotland whereby such things became possible. Mr. Balfour definitely committed the Government of that day to look into the whole question of the position of parochial medical officers in Scotland. A practical result followed upon this important debate, for Mr. Weir moved Parliament for a return showing the number of medical officers dismissed by parish councils in eachcrofting county during each year from 1895 to 1901 inclusive, the name of the parish council, and the cases in which a cause of dismissal was assigned. The return as issued is given on the next page.

It will be seen that in seven years—*i.e.*, from 1896 to 1902—16 medical officers were dismissed by their parish councils, 10 of whom received no reason whatever for the termination of their engagements. Upon this return being made public a wide feeling of insecurity was felt among Scottish parochial medical officers, which was not decreased by looking closer into the facts. The return deals only with dismissals, but the resignations were known to be at least as numerous. Some parish councils in Scotland were clearly unable to appreciate the difficulties and responsibilities of medical practice. Stung by various petty annoyances and wounded by the advantage taken of their subservient position, many medical

officers in the Scottish Poor-law service have been compelled to resign office in the interest of their honour and of the dignity of their profession.

*Return of Medical Officers Dismissed by Parish Councils
since May 15th, 1895.*

County and Parish.	Number of medical officers dismissed.	Date.	Whether cause for dismissal was assigned.
Argyll :			
Kilfinichen	1	1897	No
Caithness :			
Halkirk	1	1896	No
Inverness :			
Ardersier	1	1902	Yes
Barra	1	1898	No
Croy	1	1902	Yes
Petty	1	1902	Yes
S. Uist	1	1898	Yes
Orkney and Shetland :			
Eday	1	1899	Yes
Evie	1	1898	No
Rousay	1	1900	No
Stronsay	1	1898	Yes
Ross-shire :			
Kincardine (parish of)	1	1896	No
Uig	1	1899	No
Sutherland :			
Durness	1	1898	No
Kildonan	1	1899	No
Loth	1	1899	No

The composition of the parish councils is largely responsible for this unfortunate state of affairs. During the 50 years of the existence of the old parochial boards, which were composed of the most influential members of the parish, the medical officers received proper treatment ; but on the passing of the Local Government Act of 1894, when the membership of the parish council was thrown open to all

ratepayers, a different spirit began to prevail. The parish councils, especially in the crofting districts, are now usually composed of the parish clergy (Established and Dissenting), lay preachers, missionaries, small shopkeepers, crofters, and fishermen. These oddly comprised bodies, more than half of whom are without education—at any rate, without any education that can enable them to appreciate the methods of self-respecting and efficient medical practice, the proper rate of pay, or the proper methods of behaviour—have unlimited power over the medical officer and in many cases, it would seem, do not fail to use it. While rendering his tenure of office miserable they can, and do, dismiss him without a reason. This is an extraordinary position of affairs and one that calls for the measure of reform virtually promised some years ago by Mr. Balfour. Inspectors of the poor and other parish officials cannot be dismissed without the sanction of the Local Government Board of Scotland and the poor-law medical officers ought to enjoy the same security. They ought to be able to feel that their work and conduct will be judged by a competent and unbiassed public department and not by a group of their neighbours, mostly their inferiors in station and knowledge.

Insecurity of tenure, however, is not the only drawback to the service. In many cases exorbitant house rents are charged and the salaries are not commensurate with any heavy expense in rent unless the private practice be lucrative. This it is not likely to be in sparsely inhabited neighbourhoods where patients live far apart and where horses have to be kept to meet their wants. The salaries have

not been raised in sympathy with the general increase in expenses, and, while never anything but small, now bear no sort of proportion either to the medical officer's needs or to the hardships that he has to undergo. During sickness, or temporary absence from the parish for a holiday or upon private business, the medical officer has to provide a substitute, who may cost him from £4 4s. to £5 5s. a week with travelling expenses and board. Other parish officials, such as ministers, poor-law inspectors, and schoolmasters, can usually get a free and even an extended holiday, and the same reasonable facilities for rest and recreation should be granted to the medical officers, not as a favour but as part of their contract for service. We are constantly told that the extreme poverty of certain districts of Scotland forbids more generous payment to the medical officers. The proper deduction is that the State should assist the community that cannot assist itself, but the plea of extreme poverty is not secure from contradiction. The financial condition of the highland and island parishes of Scotland has materially improved of late years, while the medical officer's position and salary, fixed by the old parochial boards, remain what they were twenty years ago, despite the greater expenses of the medical man's education and the far more costly equipment of medical practice.

The Scottish Poor-law Medical Association upon these grounds is prepared to advise medical men who are thinking of applying for parochial appointments in the highlands and islands of Scotland to communicate with the out-going medical officer on the following points:—

1. The character and general attitude of the parish council towards the medical officer.

2. The house accommodation and the rent of the house.

3. The adequacy of salary as medical officer to the paupers.

4. The arrangements for holiday and sick leave.

These are the concessions which in the opinion of the Scottish Poor-law Medical Officers' Association are necessary to make the office of a poor-law medical officer in the highlands and islands of Scotland worth retaining:—

1. The right of appeal to the Local Government Board of Scotland against unjust dismissal.

2. Free official residence.

3. Increased salary, chiefly in the form of increased fees for attendance on midwifery cases and cases of serious surgical injury, and for the certifying of lunatics.

4. Annual free holiday of reasonable length and a ree substitute in case of sickness.

5. Superannuation allowances.

A departmental committee of the Local Government Board, after a close inquiry, has recommended the granting of the first two reforms, but it is to be hoped that the promises of general reform that have been made will not be lost sight of either by the medical profession or by Parliament. State aid is required. The simplest form in which that aid could be granted would be by the erection of the poor-law medical officers into assistant medical officers of health. To such officers, properly salaried, might be confided all the local duties of medical attendance

upon infectious disease, of inspection of schools, workshops, bakehouses and abattoirs, and they might be put in charge, under the county medical officer, of the necessary statistical returns of public health. There is no need in Scotland for a sanitary official distinct from a poor-law officer, and the care of the sick poor could best be undertaken by those who are responsible for the sanitation of their environment—only money, not much of it, being wanted to carry out this reform.

THE POOR-LAW MEDICAL SERVICE IN IRELAND.

The condition of the poor-law medical service in Ireland has for many years been a scandalous blot on the administration of the country. Politicians, journalists, and enlightened general opinion have condemned the system; the medical press has called persistently for its improvement; the Irish Medical Association more than four years ago published a statement of studied moderation every word of which showed the necessity for immediate reform; the leaders of medical opinion in Ireland, in the medical schools of Dublin, Belfast, Galway, and Cork have advised their pupils not to take office in the service—advice which has not been neglected; and the Local Government Board of Ireland, under whose jurisdiction the dispensary districts lie, has admitted the necessity of ameliorating existing conditions. But nothing has been done that really counts when the magnitude of the evil is realised.

In the same way as the case of Mr. Lamont serves to illustrate by one lurid story the troubles of the Scottish poor-law medical officer, so the infinitely

sadder event of Mr. William Smyth's heroic death, which occurred two years later, may be regarded as a supreme example of the trials of the poor-law medical officer in Ireland. Here the sacrifice of a noble life proved terribly, dramatically and finally that the poor-law medical service in Ireland must be reformed. Mr. Smyth was dispensary medical officer of Dungloe, county Donegal, and died from an attack of typhus fever contracted in his efforts to fight that disease which had broken out in part of his district, the island of Arranmore on the western seaboard of Donegal. Mr. Smyth was most anxious to remove his patients to the isolation hospital at Glenties on the mainland, but met with such opposition that Dr. McCarthy, the Local Government Board inspector, was sent to his assistance. As the fishermen would neither lend their boats nor row the fever-stricken patients across, an old and unseaworthy boat was purchased by the relieving officer, and the two medical men, plying unskilful oars, set off for the island. Here fresh difficulties arose, as the friends of the patients opposed all removal, which was accomplished by the aid of the police. On the homeward journey the medical men hailed a boat which was manned by six policemen and asked to be taken in tow to Burton Port, but the policemen refused to render any assistance, fearing infection. Tired out with their unaccustomed exertions the two intrepid rowers reached Burton Port at last, where an ambulance awaited their arrival, and the patients were removed to Glenties. Mr. Smyth caught typhus fever and died in a few days, a veritable martyr to his splendid sense of duty.

This narrative epitomises the position of the poor-law medical officer in Ireland. Here we have a man left single-handed amid a frightened, ignorant, callous peasantry, to combat a dangerously infectious disease as best he could. The sea must be passed before he can reach the hovels of the sick; he has no skilled assistance and no lay assistance. The representatives of the department under which he works give strenuous help at the last, but the dispensary medical officer dies at his post. And he dies for no purpose, for if similar circumstances arose to-day there would be a similar issue.

The Dispensary Medical Officers are the poor-law officers, sanitary officers, and general practitioners of Ireland, and a large proportion of the Irish population comes into contact with no other medical men. Few people in England understand the hardships under which the poor-law medical officers work in Scotland or Ireland, and some may even be content to believe that the attitude of the bureaucracy, which stigmatises the officers of both services as chronic malcontents, is justifiable, but it is not.

The main grievances of the medical officers of the poor-law system in Ireland are the hardship of their work, the scantiness of their pay, the absence of promotion, the difficulty of obtaining holidays, the absence of definite arrangement for superannuation pensions, and their anomalous position as servants of the poor-law guardians. These grievances can be conveniently considered in the order in which I have set them down.

The following are the duties appointed for the dispensary medical officer by the Irish Local Government

Board in respect of the dispensary work. He must attend the dispensaries on such days and hours as the Local Government Board may direct and afford outdoor medical relief to all poor persons presenting the "black ticket" for dispensary treatment. He must attend the patient's residence when he receives a "red ticket" and treat the case to its fortunate or unfortunate issue. He must keep a register of all patients attended either at their homes or at the dispensary, and send the book monthly for inspection by the guardians, and he must also give a certificate, if needed, of the state of health of any dispensary patient if called upon to do so by the guardians. He must keep stock of his drugs and appliances and make a quarterly application to the Local Government Board for new supplies. He must almost invariably dispense his own medicine, for the last annual report of the Local Government Board of Ireland shows that in 746 dispensary districts only 47 "compounders" or dispensers are kept. He must send samples out of each consignment of drugs to be tested, he must pack up and return all empties. He must report to the guardians monthly his hours of attendance and the duration of his stay at the dispensaries. He must send quarterly to the Local Government Board and to the board of guardians a statement showing the number of tickets issued, the number of tickets cancelled, and the number of lunatics certified, as well as the number of cases that have occurred of small-pox, typhus fever, diphtheria, typhoid fever, and scarlet fever. He must answer questions about dispensary arrangements and anything else that either authority may want to know.

The tickets alluded to as "red" or "black" are in the gift of the guardians, and are issued by them personally or through their relieving officers, or wardens, to the sick poor. The black ticket entitles its holder to medical advice and medicine at the dispensary; the red ticket is an order to the medical officer to visit the patient at his home. The guardians are supposed to be the sole judges of who is "poor," but the wardens, as the official ticket issuers are called, can distribute the tickets as they like, and they frequently abuse the discretion vested in them. This does not signify greatly in the matter of the black ticket, for the medical officer has to attend at the dispensary at certain hours, and it does not make much difference to him, when he is there, if some of the patients to whom he has to administer charitable relief can really pay for his services. True every such abuse of the system diminishes the medical man's chance of making money out of private practice, but in many districts of Ireland this chance is so slight that the luckless medical men see it made slighter without particular resentment. But the matter is different when red tickets are abused. The red ticket is an order, and some boards of guardians construe it as a peremptory order, to visit the sick at their own homes. These homes may lie widely apart from each other and from the medical officer's house, journeys in cars over vile roads or in boats over rough seas may be necessitated, so that anything like an abuse of the issue of red tickets leads to most serious consequences. The medical man's time is occupied in long and unremunerative travel, and his shallow purse is drained by boat- and cart-hire. But

these things do not prevent the wrongful issue and employment of red tickets, while unfortunately it is not easy to say in Ireland who is and who is not entitled to the benefits of rate-paid medical attention.

So much for the dispensary officer's duties as a dispensary officer pure and simple, and they would seem to account for most of his time. The dispensary medical officer is, however, medical officer of health for his district also, and the whole sanitary administration of rural Ireland, such as it is, is in his hands. The larger cities, Dublin, Belfast, Londonderry, Limerick, and Cork, for example, have a proper medical officer of health, but there is no provision of county medical officers as obtains in Scotland. The dispensary medical officer is the only person in the country side with an elementary knowledge of sanitation, but he is powerless to do anything. His additional salary as health officer amounts only to some £20, his time is over-occupied with his dispensary duties, he may have a few private patients to whom he must give a certain amount of attention, while he feels that any efforts which he makes towards improving matters will be largely wasted. The people will not understand his object and the majority of his uneducated masters, the guardians, will share their ignorance. The dispensary medical officer is also the public vaccinator, factory surgeon, and very usually the registrar for births, deaths, and marriages. For these appointments he receives small fees, which he is glad to earn. He also attends the men of the Royal Irish Constabulary Force, and the Coastguard and lighthouse staff. This brief

enumeration of the work performed by the dispensary medical officer displays him as no idler.

The average pay is a fraction above £100 per annum as dispensary medical officer, to which pittance has to be added from £10 to £25 received for the discharge of sanitary duties. But with this addition we find that out of 810 dispensary medical officers 500 receive less than £150 per annum, only 2 receive more than £200, and 32 receive under £100. Fees of 2s. 6d., 2s., 1s., and 6d., as registrar, vaccination officer, certifying factory surgeon, and surgeon to the Royal Constabulary, and the Coast-guard and lighthouse staff have also to be added, and like the English guardians the Irish guardians point to vaccination fees as an excuse for low salaries. In the dispensary service there is virtually no promotion, so that a man cannot comfort himself for taking a small salary while he is young with a feeling that as he grows older, and the expenses of a family begin to fall upon him, his income will increase to meet his needs. Nor is there any certainty of a pension. It is within the discretion of the board of guardians to grant a pension to a retiring dispensary officer, but they can refuse it to anyone who has offended them. Then the unfortunate medical man, who cannot be expected to have made any great provision for old age out of his income, must toil on in harness until he dies, being forced by penury to continue the work, however unfit to do his duties.

Tables I. and II. show the superannuation allowances, some of them terminable at a certain date, of all medical dispensary officers and workhouse medical officers paid during the year ending March 31, 1903,

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TABLE I.—*Medical Dispensary Officers.*

Number.	Age.	Service.	Salary.	Super-annuation.	Number.	Age.	Service.	Salary.	Super-annuation.
1	53	19 $\frac{1}{3}$	£112	£56	36	60	29 $\frac{1}{4}$	£130	£84
2	50 $\frac{1}{2}$	20 $\frac{1}{4}$	104	52	37	60 $\frac{1}{2}$	24 $\frac{3}{4}$	130	70
3	69 $\frac{1}{6}$	30 $\frac{3}{8}$	127	63	38	62 $\frac{1}{2}$	39 $\frac{3}{8}$	131	85
*4	70 $\frac{9}{12}$	42 $\frac{3}{8}$	198	130	39	Not given.	14	141	90
*5	75	48 $\frac{1}{4}$	128	85	40	61 $\frac{1}{4}$	30 $\frac{1}{8}$	155	95
6	66	30 $\frac{2}{3}$	152	50	41	53 $\frac{1}{6}$	28	129	82
*7	76 $\frac{1}{2}$	42 $\frac{2}{3}$	139	92	42	60 $\frac{1}{2}$	18 $\frac{7}{12}$	131	45
8	67 $\frac{8}{12}$	43 $\frac{5}{12}$	179	119	43	68 $\frac{5}{12}$	33 $\frac{5}{12}$	137	91
*9	78 $\frac{8}{12}$	51 $\frac{1}{4}$	133	88	44	50 $\frac{3}{8}$	26 $\frac{1}{6}$	120	50
*10	68 $\frac{1}{12}$	43 $\frac{7}{12}$	154	102	45	55 $\frac{7}{12}$	32 $\frac{7}{12}$	143	95
*11	63 $\frac{5}{12}$	39 $\frac{5}{12}$	108	72	46	61 $\frac{1}{2}$	33 $\frac{1}{2}$	138	92
*12	83 $\frac{1}{12}$	31	286	191	47	68 $\frac{3}{4}$	38 $\frac{7}{12}$	150	110
13	58 $\frac{7}{12}$	29 $\frac{1}{12}$	198	129	48	65	21 $\frac{7}{12}$	100	35
14	58 $\frac{2}{12}$	25 $\frac{1}{12}$	126	74	*49	70 $\frac{1}{12}$	37 $\frac{3}{4}$	235	145
15	60 $\frac{1}{4}$	28 $\frac{1}{12}$	109	69	50	69 $\frac{3}{8}$	36	133	88
*16	67 $\frac{2}{8}$	34 $\frac{1}{8}$	277	185	51	57 $\frac{6}{12}$	32	133	89
17	45 $\frac{9}{12}$	21 $\frac{2}{12}$	103	35	52	56 $\frac{1}{4}$	28 $\frac{5}{8}$	149	94
18	64	28 $\frac{8}{12}$	161	100	53	57 $\frac{3}{8}$	20 $\frac{3}{8}$	132	60
19	47 $\frac{1}{8}$	21 $\frac{1}{8}$	106	51	54	57	30	136	75
20	56 $\frac{5}{8}$	28 $\frac{1}{8}$	106	67	55	57	16 $\frac{5}{12}$	191	51
21	74 $\frac{1}{12}$	38 $\frac{9}{12}$	119	75	56	59 $\frac{5}{8}$	31	173	115
22	39 $\frac{3}{12}$	16	128	44	57	28	$\frac{1}{12}$	151	2 10s.
*23	72 $\frac{3}{4}$	45 $\frac{1}{12}$	173	112	*58	71	29	148	99
24	69 $\frac{1}{6}$	26 $\frac{1}{2}$	171	60	59	45 $\frac{7}{12}$	20 $\frac{1}{4}$	172	62
25	56 $\frac{1}{6}$	30	153	102	60	58	22 $\frac{1}{2}$	127	50
*26	71 $\frac{1}{12}$	45 $\frac{9}{12}$	174	116	61	45 $\frac{1}{8}$	11 $\frac{3}{4}$	123	43
27	36 $\frac{8}{12}$	9 $\frac{1}{12}$	126	31	62	48 $\frac{1}{2}$	23 $\frac{1}{12}$	128	48
28	69 $\frac{1}{4}$	24 $\frac{5}{8}$	156	88	*63	78 $\frac{1}{12}$	45 $\frac{5}{8}$	121	81
29	55	29	289	139	64	51 $\frac{5}{12}$	25 $\frac{2}{12}$	171	80
30	66	25 $\frac{1}{2}$	163	95	65	53 $\frac{1}{12}$	29	112	72
31	66	30 $\frac{2}{3}$	162	108	*66	76 $\frac{7}{12}$	54 $\frac{7}{12}$	170	98
32	40	14 $\frac{4}{12}$	151	60	67	55 $\frac{3}{12}$	31 $\frac{7}{12}$	153	79
33	64 $\frac{1}{12}$	24	139	71	68	64	37 $\frac{4}{12}$	168	112
34	53 $\frac{1}{12}$	23	155	85	69	76 $\frac{2}{3}$	38 $\frac{4}{12}$	157	134
35	40	11 $\frac{9}{12}$	145	50					

TABLE II.—*Workhouse Medical Officers.*

Number.	Age.	Service.	Salary.	Superannuation.
1	67 $\frac{8}{12}$	43 $\frac{2}{12}$	£90	£60
2	61	32	150	80
*3	78 $\frac{1}{6}$	44 $\frac{1}{6}$	130	86
4	57 $\frac{5}{12}$	28 $\frac{1}{12}$	80	50
5	63	30 $\frac{7}{12}$	244	160
6	32 $\frac{3}{4}$	4 $\frac{5}{12}$	60	7
7	57	28	120	80
*8	65	41 $\frac{5}{12}$	80	53
9	50 $\frac{2}{3}$	22	90	48
10	42 $\frac{2}{3}$	16 $\frac{7}{12}$	60	20
11	51 $\frac{1}{2}$	25 $\frac{1}{2}$	110	64
12	67 $\frac{1}{12}$	38 $\frac{2}{3}$	100	63
*13	70	37	100	66

which I have extracted from the figures in the last report of the Local Government Board of Ireland. The age, period of service in years, and salary are also given.

These figures, taken as a whole, form an unanswerable indictment of the system. We have only to look at the long average length of service and the low average size of pension to come to this conclusion. I have placed an asterisk (*) against a few special cases. It will be seen that out of 82 hard-working men 13, or nearly one-sixth, were compelled to remain in harness until over 70 years of age, one working until his eighty-fourth year. The Local Government Board of Ireland acknowledges that this position exists but seems unable to bring itself to take the initiative in promoting any remedy. No one should be placed in circumstances like those of the Irish dispensary medical officer and be compelled to abide in them until old age overtakes him, because he has been unable to make provision for the end of life, and has no certainty of obtaining a pension. Note the case of the dispensary medical officer numbered in the first table "63" who was for 45 years in the service, and who, when verging on 80 years of age receives a pension of little more than 30s. per week. From one such text a sermon of complete indictment of the whole system could be preached. Note, also, the number of retirements at an unusually early age. The cause assigned to most of these retirements is physical breakdown. The exacting nature of the life of the Irish dispensary medical officer could not be shown in a more lurid way, and a factor in producing this frequent breakdown is the monotonous persistency of the work. There is no definite regulation providing for any recreation or

holiday leave for the medical officers. Until recently the medical officers got no holiday at all. The guardians refused to make any grant towards the expenses or the fees of a substitute, and the medical officer never had money enough to pay a substitute and also to go away. And so, to the manifest detriment of his own interests and those of the community whom he served, he remained day in and day out on his dreary rounds. The position has been improved by a general order made in 1899 by the Local Government Board of Ireland for an annual vacation not exceeding four weeks for each medical officer, while three years later recoupment was provided from the Board of one-half of the amount paid by the guardians with the Local Government Board's sanction. It will be seen that the unfortunate medical officer has to get the acquiescence of the guardians, who in their turn have to get the sanction of the Local Government Board. There ought not to be any necessity for all this routine. In every walk of life it is now recognised that a hard-working employé has a right to a holiday, that he ought to be allowed to go on his holiday in enjoyment of his salary, and ought not to be taxed by having to pay a substitute. The fact that many, a majority, of the officers of the Irish Medical Poor-law Service do now get these fitting opportunities for a vacation shows that the local authorities who control the service are waking up to the situation. Soon the officer's right to a holiday will be taken by him as a right: at present it is yielded to him after requests, and perhaps bickering, as a concession.

And over and above all these grievances there is the medical position to be remembered. Always the

razor is used to cut the firewood. The scientific man is never spared, if the guardians or the Local Government Board of Ireland can help it, by a proper supply of assistants to take the lower administrative details off his hands. Imagine 746 dispensary districts with but 47 compounders, and 119 dispensary assistants among them, so that the great majority of the dispensary medical officers have to dispense their own medicine. Again, there is a dearth of midwives who might act as assistants to the medical officers and spare them much arduous waiting and watching, for 551 women do not go far when it is remembered how much of the country the poor relief system of Ireland has to serve. The unpacking of medicines, the despatching of samples, and the returning of empties, clearly the work of a boy or porter at a few shillings a week, have to be done in most cases by the medical officer himself. Then his clerical work has to be considered. He has to keep records of his work to be shown to the guardians, he has to supply statistics for the consideration of the Local Government Board, and no amount of overwork is allowed to excuse a default.

Reform is urgently needed and everyone knows it. There should be better pay, there should be more assistance, the dual control of the dispensary medical officers by central and local authority should be less vexatiously in evidence, the elections of the medical officers should be managed on proper principles, and the Local Government Board should support the medical officers where the local authorities try to oppress them. Everyone knows the crying need of these things, but nothing is done.

CHAPTER XI

THE PRESENT STATE OF MEDICAL EDUCATION

The Universal Scheme.—A Tabular View of the Five Years' Curriculum.—The Registration of the Medical Student.—The English Colleges resist the General Medical Council.—The Societies of Apothecaries.—Some Comparisons.—The General Medical Council and the Final Examinations.

THE state of the medical profession in respect of its professional position has now been described, and we see that it is a sound one, though under its various aspects there are many things that require alteration, and though grave abuses exist which could be righted immediately if only the mischief of them were properly appreciated by the public. A profession which brings to so large a proportion of its followers a fair measure of practical success, which can be pursued in such different environments, and which offers in its mere pursuit such high intellectual and moral pleasures, cannot possibly be regarded as other than a good one, even if it may be easy to show many directions in which it might be bettered. In fact, the obviousness of the drawbacks justifies us in believing that alteration for the better may be expected. But no picture of the present position of medicine, either of its practice or of its relations to the public, can be complete which does not deal with medical education.

The solution of the troubles of the medical life, almost as much as the intellectual pleasures of that life, lies in the acquisition of scientific knowledge and the practical power to apply the same. By a high level of professional learning, and by this only, can medical men deserve the consideration of the public and command a respectful hearing when seeking any improvement in the conditions of medical practice. And at a time when educational questions are of absorbing interest to every thoughtful person, at a time, also, when the technical instruction provided by Great Britain is often compared disadvantageously with that in other countries, it will be right to discuss the curriculum of the medical student in detail. The actual studies which the law imposes on him are not of importance to medical men only. The public purchases and relies upon medical advice, and should be interested to know what grounds there are for believing that it obtains a highly-finished article—a more highly-finished article, in fact, than is offered to the public of most other nations.

The position of medical education in Great Britain and Ireland at the present day is in a similar plight to the professional position. It is in many particulars open to amendment, but the principles, as laid down by the statutory educational bodies and endorsed by the General Medical Council, appointed by Act of Parliament as the co-ordinating authority, are sound. The desire of the General Medical Council ever since its institution has been to secure an adequate curriculum for the medical student, so that the medical practitioners of England, Scotland, and

Ireland, through whatever qualifying body as a medium they might enter the medical profession, should be up to a good, even to a high, standard of efficiency. As this has also been the aim of the various qualifying bodies, the great majority of which were in existence years before the institution of the General Medical Council, the educational work of the Council has been simplified. The Council, however, has recently been confronted with difficulties mainly arising from the general development of medical knowledge, and the consequent increase of subjects for which space has to be found in the student's curriculum, but due also to a want of complete accord in the aspirations of all the qualifying bodies and to the special circumstances which surround the medical student at the London schools.

The scheme which the various qualifying bodies have adopted by a sort of general consensus of opinion, and which is approved of by the General Medical Council, may be summarised as follows. Firstly, the student must pass a preliminary examination, which is not of a stringent character, in fact, it seems that almost any initial test answers the purpose. Secondly, he must enter upon a five years' curriculum from the date of passing that examination, during which he must submit himself to three tests—a preliminary scientific examination, an intermediate examination, and a final examination. The preliminary scientific examination, the subjects of which are chemistry, botany, biology, and physics, should be passed at the end of the first year; the intermediate examination, the subjects of which are anatomy and physiology, should be passed at the end of the third year; the

final examination, the subjects of which are medicine, surgery, and obstetric medicine, should be passed at the end of the fifth year. Hence, the first year of the medical student's curriculum should be devoted to the more or less elementary study of the sciences which he will later find are necessary to the comprehension of medicine—the ancillary sciences; the next two years should see him in the dissecting-room and the physiological laboratory, learning to appreciate the shapes, dispositions, relations, and functions of the normal human body as the only method of detecting and understanding any lapses into disease or pathological conditions due to injury; and the last two years of the curriculum will be spent in the wards and out-patient departments of a hospital.

The medical curriculum has been extended in obedience to the vastly greater scientific and professional equipment that is now required of the medical practitioner, in whatever branch of medicine he may be called upon to practise. Many years ago it was extended from three years to four, while a change made twelve years ago extended it from four years to five. Each change necessitated a re-arrangement of their examinations upon the examining bodies, and the result is that at the present moment a great similarity appears in the educational course of all of them, every student having the same subjects to read and to acquire practically in the same space of time. Consequently the state of medical education in the three countries at the present day can be discussed as a more or less uniform thing, arranged upon a definite pattern by the respective qualifying bodies and supervised by one authority—the General Medical Council.

This uniformity may be insisted upon a little, for it is exactly what would *not* be expected to exist where over twenty educational institutions, having their homes in different countries and drawing their *clientèle* from different classes, compete against each other for the patronage of the student requiring a qualification. The fact that at the present time, under a system in which many faults of detail can be found, a high general level of education is maintained, making downgrade competition improbable, is very striking. And it has a forcible bearing upon suggestions for reform because it implies that the existing condition is a sound one, and that nothing is required save to simplify it (1) by removal of the anomalies that are due to its growth into a whole from many separate directions, and (2) by resistance to unnecessary developments undertaken with the vain hope of examining students, whose season of acquisition must be limited, in all the unlimited extensions of modern medicine.

The simplest manner to obtain a bird's-eye view of the present state of medical education in England, Scotland, and Ireland will be to consider the curriculum of the student as enjoined by the different qualifying bodies in connection with the supervision exercised over this curriculum by the General Medical Council. The part played by the General Medical Council is to admit the student to the roll of the profession when he is successful in obtaining the necessary qualifications, and to see that those qualifications are adequate. The part played by the qualifying body is to examine him at different stages of his career. The fact that there is a general likeness

TABLE I.—THE EXAMINATION SCHEME OF THE UNIVERSITIES.

University.	Matriculation.	Preliminary Scientific Examination.	Intermediate Examination.	Final M.B. and B.C. Examination.	M.D. Examination.	M.C. Examination.
Cambridge.	Medical student begins curriculum by passing the First Examination of the Arts course, by graduating in Arts, or by obtaining a certificate from the Oxford and Cambridge Examining Board.	First Examination for M.B.: Chemistry, and Physics, and Biology.	Second Examination for M.B.: Anatomy and Physiology. The standard is high.	Third Examination for M.B.: Part (1) Pharmacology and General Pathology. Part (2) Surgery, Midwifery, and Practice of Physic. The two parts may be taken separately.	Presentation of thesis and writing of an extempore essay.	Examination in Operative Surgery. An extempore essay has to be written.
Edinburgh.	A Matriculation Examination has to be passed of ordinary standard implying a knowledge of classics and English.	First Examination for M.B.: Chemistry, Botany, and Physics.	Second Examination for M.B.: Anatomy, Physiology, Materia Medica, and Therapeutics.	Final Examination for M.B. and B.C.: Part (1) Pathology, at end of fourth winter session. Part (2) Surgery, Medicine, Midwifery, Forensic Medicine, and Hygiene, at end of fifth year.	Presentation of thesis and Examination in Clinical Medicine.	Examination in Operative Surgery. A thesis has to be written.
Royal University, Ireland.	The Matriculation Examination is of similar standard to that of other universities.	First Examination for M.B.: Systematic Chemistry, Zoology, Botany, and Physics, or Natural Philosophy.	Second and Third Examinations for M.B.: Part (1) Anatomy, and Physiology, and Practical Chemistry at the end of the second medical year if one year has elapsed since passing the First M.B. Part (2) At the end of the third medical year: Anatomy, Physiology, and Materia Medica.	Final Examination for M.B. and B.C.: Part (1) Medicine, Therapeutics, Pathology and Hygiene. Part (2) Surgery and Surgical Anatomy. Part (3) Midwifery and Diseases of Women. Each part of the examination must be passed as a whole.	A clinical examination. Bedside diagnosis and treatment of cases.	Written and clinical examination in all subjects.

TABLE II.—THE EXAMINATION SCHEME OF THE CONJOINT BOARDS OF ENGLAND, SCOTLAND, AND IRELAND.

Name.	Entrance Examination.	First Professional Examination.	Second Professional Examination.	Third Professional Examination.
English Conjoint Board (Royal College of Physicians of London and Royal College of Surgeons of England).	Any examination approved by the General Medical Council.	Chemistry and Physics, Practical Pharmacy, and Elementary Biology. Examination can be taken in three parts and Pharmacy can be taken at any stage in the curriculum.	Anatomy, Physiology and Histology. Both subjects must be passed together.	(a) Medicine, Pharmacy, Forensic Medicine, and Public Health. (b) Surgery and Surgical Anatomy. (c) Midwifery and Diseases of Women. Examination can be taken in three parts and Part (c) can be passed at end of fourth year.
Scottish Conjoint Board (Royal College of Physicians of Edinburgh, Royal College of Surgeons of Edinburgh, and Faculty of Physicians and Surgeons of Glasgow).	Any examination approved by the General Medical Council.	Chemistry, Elementary Anatomy and Physiology, and Histology.	Anatomy, Physiology, Materia Medica, and Pharmacy.	(a) Medicine, Clinical Medicine, and Therapeutics. (b) Surgery and Surgical Anatomy. (c) Midwifery and Gynaecology. The three subjects may be passed separately.
Irish Conjoint Board (Royal College of Physicians of Ireland and Royal College of Surgeons in Ireland).	Any examination approved by the General Medical Council. Colleges also hold a preliminary examination.	Chemistry, Physics, and Elementary Biology.	Anatomy, Physiology, and Histology.	(a) Pathology, Pharmacy, Public Health, and Hygiene, which may be passed at the beginning of the fourth year. (b) Medicine, Surgery, and Midwifery. Candidates may present themselves for examination in the subjects separately.

between all the educational plans of the qualifying bodies will be seen by an examination of the preceding two small tables. The first table sets out the examination scheme of three universities, those of Cambridge, Edinburgh, and Dublin; the second sets out the examination scheme of the Royal Colleges of Physicians and Surgeons of the three countries. The examinations of the two Societies of Apothecaries will be found separately treated. The exact details of all the examinations of all the bodies are published annually in their respective calendars, and are summarised, also annually, in the Students' Numbers of *The Lancet*. There is no need to recapitulate particulars which have been published so frequently and which are so completely accessible. I have chosen, to illustrate the homogeneity of all the educational schemes laid down for the medical student, the schemes of six educational bodies, a university and a corporation in each division of the kingdom. Looking a little more closely into the details of these schemes, we see their similarity to each other, and if we compared them with the schemes of other bodies we should find that the differences here were mainly superficial.

The first step in the education of the medical student is his registration, and the registration of a student is not compulsory. The General Medical Council has laid down regulations in reference to the registration of students which are very precise, but there is nothing in the Medical Acts making it incumbent upon the student to enter his name with the Council at the commencement of his studies. It is sufficient for his name to be enrolled by his

qualifying body upon passing one of the statutory examinations; that body becomes responsible for not admitting him to his final examination until five years later.

The preliminary examination, as provided for by the General Medical Council, supposing the student not to begin his studies by passing any recognised test at his university or corporation, is of fair scope. The following is the schedule :—

1. English language, including grammar and composition.
2. Latin, including grammar, translation from unprescribed Latin books, and translation of English passages into Latin.
3. Mathematics, comprising arithmetic, algebra, including easy quadratic equations, geometry, the subject-matter of Euclid, Books I., II., and III., with easy deductions.
4. One of the following subjects : (a) Greek, (b) a modern language.

A degree in arts of any university of the United Kingdom or of the Colonies, or a certificate of having passed the final examination for a degree in arts or science of any university in the United Kingdom, is considered a sufficient testimonial of proficiency for admission to the Students' Register or to the commencement of medical study. There are many examining bodies whose examinations in general education are recognised by the General Medical Council as qualifying for registration as a medical student. At the Universities of Oxford and Cambridge graduates are admitted to registration, while the undergraduates of these universities are exempt from any preliminary examination before commencing medical studies if they have passed certain standards in the local examinations, have obtained certificates

from the Oxford and Cambridge Schools Examination Board, or have passed the first and second tests for the ordinary arts degrees, viz., "smalls" or "moderations" at Oxford, "little-go" or "general" at Cambridge. The Universities of London, Victoria, Birmingham, Liverpool, the Royal University of Ireland, and the University of Wales all have a matriculation, and those who have passed this test at their respective universities can commence their medical studies. The University of Dublin has an entrance examination, while the Universities of Edinburgh, Aberdeen, Glasgow, and St. Andrews have an inaugurating test for their students in the preliminary examination of the joint board of examiners for graduation in arts or science or medicine and surgery. The College of Preceptors in England holds a preliminary examination for medical students and also a general examination for first-class certificates. Satisfaction of either test will admit a student to medical studies. In Ireland the middle and senior grade examination of the Intermediate Education Board, in Scotland the leaving certificates of the Scottish Education Department, and in Wales the senior certificate of the Central Welsh Board will do the same. There are regulations by which students at colonial, Indian, and foreign universities can obtain admission to the Students' Register, concerning which it is enough to say that the General Medical Council has to be satisfied of the adequacy of the test. The Conjoint Examining Board of the Royal Irish Colleges holds an examination which is approved of by the General Medical Council, but there is nothing of the sort at the other two Conjoint Boards.

Although the medical student, as we have said, need not register with the General Medical Council, it is necessary that he should pass one of the approved examinations in general knowledge before entering upon his five years' curriculum, and that he should not be admitted to the final examination of the qualifying body until he has completed that curriculum. It seems, therefore, a small point that he is not compelled to register, seeing that whether he registers or not he has to be a medical student for five years, but upon it hangs a very important issue, one that has been recently the subject of difference of opinion between the English Royal Colleges and the General Medical Council—a difference of opinion now in abeyance rather than settled. The General Medical Council has objected to the standard of scientific education required at the preliminary scientific examination of the English Conjoint Board. The English Conjoint Board accepts certificates that its students have undergone instruction in chemistry, botany, and physics at certain named public schools and institutions. Supposing a student, who has passed his entrance examination in general education, possesses satisfactory proof of having attended courses in preliminary science at one of these schools, he can be admitted to the preliminary scientific examination of the English Conjoint Board ; and, if he passes the examination, he can at once proceed to the study of anatomy and physiology, having apparently shortened his period of professional study to four and a half years by doing his preliminary scientific work at school and counting the time so spent as six months of his medical curriculum. Some may say, Where is

the harm? There is no harm if the preliminary scientific examination is sufficiently difficult. To practical minds it cannot matter a tittle where the student acquires his knowledge of the ancillary scientific subjects if only he acquires sufficient, but this is the point upon which the General Medical Council desires to be satisfied. The Council is the central authority, and it is its duty to make certain that the curriculum cannot be abbreviated in a manner that is either unjust to the public or advantageous to some qualifying bodies more than to others. The difficulties are considerable. The General Medical Council for practical reasons cannot watch over the scientific courses given in public schools, so that the only way in which its power and responsibility of supervising medical education can be exercised is by ensuring that the examination in the work purporting to be done at such schools is particularly rigid. The English Conjoint Board has resented the strictures of the General Medical Council upon the preliminary scientific examination of the Board, and this feeling is intelligible, for the Board has taken great trouble to ensure that the examination is adequate and that the instruction at the various schools is good. Negotiations between the two parties were not conducted with complete urbanity. No one who knows anything of medical education can possibly fail to appreciate the fact that the professional examinations of the English Conjoint Board are remarkably thorough and well conducted. The men who pass the final examinations of this Board meet with the most uniform success in other competitive examinations, and in every way show that they are able to

hold their own with the possessors of so-called "honour" degrees. This fact makes it especially galling for the Board to have its preliminary scientific examination called in question, and the Board would probably desire to take up the attitude that the General Medical Council, being concerned only in seeing that the men who apply for registration as qualified medical men are duly instructed, should confine its inspection of examinations to the finals. The contention does not hold water. It is not possible to say that education begins in one place rather than in another, and it is the manifest duty of the General Medical Council to inspect any portion of the curriculum of any one of the qualifying bodies and to demand any necessary alteration. The English Conjoint Board, having lent itself to the appearance of shortening the medical curriculum, ought not to consider the General Medical Council to be inspired by any unfair animus if the Council reflects upon the character of the preliminary scientific training demanded by the Board; and the action of the Board in signifying that for the future its medical students need not register seemed at one time to be likely to meet with reprisal. A Bill was projected by the General Medical Council making the registration of the medical student compulsory, but the measure was dropped when it was found that the English corporations were not alone in their attitude, but that some of the other qualifying bodies also objected to the proposed legislation. The zeal of the Council for the registration of the student was not, as a matter of fact, due so much to a desire that every student should commence his studies upon a national students'

roll as that he should contribute a fee for registration to the coffers of the Council. It may have been consciousness of this fact that led the Council to drop the Bill with readiness.

The two preceding tables show the scheme of the medical curriculum of the various universities and corporations, and show it to be uniform. The educational schemes of the two Societies of Apothecaries are not quite on the same model, and can be best described by brief summaries.

SOCIETY OF APOTHECARIES OF LONDON.—There are two examinations for the Licence of this Society—the Primary and Final. The Primary Examination consists of two parts. The Licence entitles the holder to registration as being qualified in medicine, surgery, and midwifery. Part I. comprises Elementary Biology; Chemistry and Chemical Physics, including the Elementary Mechanics of Solids and Fluids, Heat, Light, and Electricity; Practical Chemistry; and Materia Medica. Part II. includes Anatomy, Physiology, and Histology. This examination cannot be passed before the completion of twelve months' practical anatomy with demonstrations, and these subjects cannot be taken separately. The Final Examination is divided into two sections. Section 1 consists of three parts. Part I. includes the Principles and Practice of Surgery, Surgical Pathology and Surgical Anatomy, Operative Manipulation, Instruments, and Appliances. Part II. includes the Principles and Practice of Medicine, Pharmacology, Pathology, and Morbid Histology; Forensic Medicine, Hygiene, Theory and Practice of Vaccination; and Mental Diseases. Part III. in-

cludes Midwifery, Gynæcology and Diseases of New-born Children, and the Use of Obstetric Instruments and Appliances. Section 1 of the Final Examination cannot be passed before the expiration of forty-five months after registration as a medical student, during which time not less than three winter sessions and two summer sessions must have been passed at one or more of the medical schools connected with a general hospital recognised by the society. Section 2 of the Final Examination consists of two parts. Part I. Clinical Medicine and Clinical Surgery; Part II., Medical Anatomy. Section 2 cannot be passed before the end of the fifth year.

APOTHECARIES' HALL OF IRELAND.—The Licence of this Hall is granted to students after five years of professional study. The diploma of the Apothecaries' Hall of Ireland entitles the holder to be registered as a practitioner in medicine, surgery, and midwifery. There are four professional examinations. The First Examination includes Biology, Physics, Theoretical and Practical Chemistry, with an examination at the bench. Pharmacy is put down in this examination, but it may be taken at any of the first three examinations. Candidates holding a pharmaceutical licence are exempt from this subject. Osteology is also a subject of the First Professional Examination. The subjects for the Second Professional Examination are Anatomy, Materia Medica and Therapeutics, Physiology, and Practical Histology. The Third Examination consists of Pathology, Materia Medica if not taken at the Second Examination, Medical Jurisprudence, and Hygiene. The Final Examination

includes Clinical and Theoretical Medicine, Surgery, with operations, Ophthalmic Surgery, Midwifery, and Gynæcology.

It will be seen that the curriculum at the three universities given in Table I., which is typical of that at the remaining universities, is practically identical with that of the Conjoint Boards. At the universities the entrance examination, in the form of an arts degree, a matriculation, or a certificate, generally demands more than the minimum approved by the General Medical Council, but none of the universities, save the University of London, makes any serious demand upon the medical student at the outset of his career. The First Examination for the M.B., or Preliminary Scientific Examination, at the universities corresponds with the First Professional Examination at the colleges, which is not strictly a professional examination at all, but an examination in ancillary subjects. The Second Examination for the M.B., or Intermediate Examination, at the universities corresponds with the (so-called) Second Professional Examination at the colleges. This examination at Oxford is called the First Examination for the M.B., which designates the examination as the first strictly professional examination. The Final Examination for the M.B., at the universities corresponds with the Third Professional Examination at the colleges. In each case the same subjects are set and the standards are roughly similar, the extent to which they may be raised being left to the individual university or corporation, while the superintendence of the General Medical Council prevents them from dropping too low. The same may be

said of examinations for the licences of the Societies of Apothecaries, where more or less an identical system of subdivision of the professional subjects prevails.

The fact that medical education, all along the lines which converge in the qualification of the student, should be so homogeneous much simplifies the task of the General Medical Council in its efforts to maintain a high standard, and should give pause to those who call out that medical education is chaotic because certain minor anomalies exist. Yet the differences which exist in the curricula are real and do harm. The Matriculation Examination of the University of London, for example, is much more difficult than any other of the examinations which confront the students on the threshold of their medical careers. It has been modified of late, but there is no doubt that far more application is required from the student to pass this examination than is required to pass any of the other entrance examinations, and the student who has passed it is able to assimilate with greater ease the subjects of the purely professional examinations, while at every other portal to the medical profession the student is allowed to enter with too little ceremony. The examinations of the College of Preceptors and of the Scottish Education Department, the Cambridge "little-go" and the Oxford "smalls" are not tests of general knowledge in the least, and the lad who has passed no more severe ordeal than these has not proved himself to be sufficiently equipped in general knowledge. His classical smattering and his scraps of mathematics will not stay by him, and if they did

they would not render his future work easier for him. If the University of London has gone too far none of the other qualifying bodies has gone far enough, and the General Medical Council might well insist upon an all-round raising of the standard of general education. The Preliminary Scientific Examination is also higher at the University of London than elsewhere, but the tendency at all the examining bodies is to improve this examination, especially in the direction of chemistry—a healthy sign, the inter-relation of chemistry and physiology, biology and pathology having now become so close. The Intermediate Examination, called First M.B. at Oxford and Second M.B. at all the other universities, is a thorough one in every instance. The student is sometimes allowed to take the two subjects separately, but it is significant that at Cambridge, where the standard of physiology is high, they must be taken together. And it is far preferable that they should be so taken. The highest standard in anatomy is that demanded by the Royal College of Surgeons of England in the intermediate examination for the degree of Fellow, but the Fellowship course is a purely honour course, and for that reason is not included in the preceding tables.

In the final examinations there are a few variations from type which call for notice. At the University of London there is a definite examination for the M.D. degree, and the medical man is desired to specialise in that degree by electing to be examined under five different headings. In the examinations for the M.B. degree at Edinburgh a certain amount of specialisation is invited, while at Birmingham the

examination is much split up into groups—a proceeding which doubtless will be convenient to the student but which cannot be commended. In Edinburgh the subject of pathology, and in Glasgow the subjects of pathology, jurisprudence, and public health, can be separated from the other final subjects and passed at the end of the fourth year. The same arrangement, with the addition of applied anatomy and physiology, holds good at the University of Dublin.

It will thus be seen that the scheme of medical education in England, Scotland, and Ireland to-day is very nearly uniform. The entrance to practice is better guarded at one door than at another, but everywhere the curriculum is well devised and may turn out good men. Moreover, the various educational bodies are zealously and constantly watched by the General Medical Council, which is never accused of being supine in respect of educational supervision. The final examinations of all the universities and corporations are tested periodically by the visitors and inspectors of the Council, and from the report which these officials make from time to time to the Council a very exact idea of the present state of medical education in the various centres can be obtained.

The process of inspection is as simple as it is drastic. The General Medical Council deposes a visitor, a member of the Council, and an inspector, not a member of the Council, who attend from time to time as the Council directs at the qualifying examinations of particular bodies. The visitor and inspector can attend together or separately as they are instructed, and can make joint or several reports.

They read some of the candidates' papers and make their own marks upon them, which they afterwards compare with the marks made by the examiners. They listen to the clinical and oral examinations of the candidates, and take note of the style of questions that are asked and the style of answer that is accepted. They observe the facilities provided for convenient examination of the candidates, the supply of instruments and pathological specimens, the precautions against copying, the amount of time allotted to the examination *vivâ voce* of a candidate or the answering of a written question. And, finally, they attend at the adjudication of the examiners upon the candidates' merits. In this thorough way they can see if the examination is kept at a proper standard and if the student obtains fair play, and there is no doubt that the criticisms of the Council's delegates, though sometimes resented by the criticised educational body, have been efficacious in maintaining a high general standard of medical training. The supervision of the Council is very real and minute, and the strictures which have been passed in some directions show that all qualifying bodies, whatever their position, are treated with the same respect, while the value of the work is proved by the fact that an indifferent report on one occasion is observed to be followed by a good report on the next occasion. The final medical examinations of the University of Oxford, for example, were reported upon to the Council in 1902, to the surprise of everyone, as not being a sufficiently rigid test of medical knowledge. A further visitation and inspection was arranged for, and took place at the end of 1904, with the result

that the previous condemnatory verdict was practically reversed. Similarly, the final medical examinations of the University of London were reported upon to the Council in 1903 in not wholly favourable terms, the chief insufficiencies noted being the unpractical character of the tests, as shown by the system of marking, and the low level of the examination in surgery. A further inspection and visitation took place in the following year, and as in the case of Oxford, the previous adverse verdict was changed. All the plans for the written papers were found to be satisfactory, the questions set in systematic surgery were considered practical, and those answers read by the inspector were creditable to the student, while it was specially stated that the standard of the examination in clinical surgery was high.

From the reports upon the different bodies having charge of the medical education of the country, which are received by the General Medical Council at its half-yearly sessions, it is clear that the Council spares no pains and favours no person in its intent to keep the medical education of the country at a high standard. The Universities of Oxford and London have been called to order freely, while the University of Edinburgh has recently had the same experience. The precautions taken with regard to the examinations are all directed towards making the tests fair towards eliminating the element of chance as far as possible from them—concerning which point more will have to be said—and towards the practical equipment of the medical man for his public duties. There is plenty of room for improvement in the general educational scheme, but as far as it goes it is

very satisfactory. All medical men must submit themselves to a carefully standardised trial before they win a place upon the official roll of their profession, and so become legally qualified to minister to the public needs.

CHAPTER XII

THE ANOMALIES OF MEDICAL EDUCATION : THE LONDON MEDICAL STUDENT

The Anomalies of the Curriculum.—The Title of Doctor.—The London Medical Student.—The Falling-off at the London Medical Schools.—The University of London to the Rescue.—The Separation of the London Medical Schools from their Hospitals.—Sir Edward Fry's Commission.—The Centralisation of Science Teaching.

OUR present scheme of medical education, though it is practically unanimous in design, and though it is regulated by a co-ordinating authority, presents an awkward number of anomalous features. For example, if we consult the calendars of the different examining bodies, we shall find that in the examination schedule of one university the subject of "physics" includes the subjects "light" and "sound" and does not do so at another; "zoology" at one place and "biology" in another appear to mean the same thing; the medical student at Oxford who has passed his first M.B. examination is in the same stage of his curriculum as his brother student at Cambridge who has passed his second M.B. examination. Consider, again, the awkwardness of the multitude of medical titles, leaving aside for the present moment the vexed and most important question of who has a right to the title of doctor. In England there are three

corporations which can grant diplomas qualifying the possessors to be enrolled upon the Medical Register, viz., the Royal College of Physicians of London, the Royal College of Surgeons of England, and the Society of Apothecaries of London. Two of the titles bear the name of the capital and one the name of the country, but the limitations implied have no existence, so that apart from their historic reason the titles are silly and misleading. In Ireland, again, we have the Royal College of Physicians of Ireland, the Royal College of Surgeons in Ireland, and the Apothecaries' Hall of Dublin ; in Scotland the Royal Colleges of Physicians and of Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow. This means that in Ireland the diplomates of the Royal Colleges are named after their country and in Scotland after their metropolitan city, as the Irish Licentiates of the Apothecaries' Hall are named, but, again, the limitations are only apparent. Everybody can practise everywhere. Again, in the Royal Colleges of Physicians of all three countries the membership is an honour diploma qualifying for admission to the Fellowship, the ordinary diploma being a Licence. In the Royal College *of* Surgeons of Edinburgh and the Royal College of Surgeons *in* Ireland (why this queer change of preposition ?) the ordinary diploma is a Licence, though there is a movement to make the Licensee a "Member," as he is styled in England. At the Royal College of Surgeons of England alone the membership is the ordinary diploma and there is no Licentiate. A Member of the Royal College of Physicians of London is the holder, that is to say, of an honour diploma

enabling him, if he have positive and negative virtues and advantageous opportunities, to become a Fellow of his College, but a Member of the Royal College of Surgeons of England holds the pass diploma of his corporation, entitling him only to a certain microscopic consideration from his corporation—so microscopic that some members may be heard to say in cold blood that their connection with their College is absolutely valueless to them. All these anomalies make it very difficult for the public to understand that not only from a legal point of view but from a professional point of view all medical men enjoy the same status—that is to say, that they all owe their places upon the Medical Register to the successful negotiation of examinations supervised by the General Medical Council in accordance with the Medical Acts. Those Acts provide but one class of medical men, viz., properly equipped practitioners, of whom an official list has to be kept, which the public may consult and so avoid the wiles of quacks. The public, however, do not understand this, and the legal profession appears to understand it every whit as little. At a police-court recently, a Licentiate of the Society of Apothecaries, giving evidence for the prosecution, was thus addressed by the solicitor for the defence : “ Yours is the lowest degree a medical man can take.” The legal gentleman was rude and ignorant—rude because the words are not those which a member of a learned profession should address to a member of another learned profession ; ignorant because there is no “ highest ” and “ lowest ” in the qualifications by which a man obtains the right to give medical evidence. If the exponents of

the law are thus betrayed into vulgar error, we can hardly blame the public for not understanding the legal position of medical men and for believing in the existence of some professional hierarchy.

But far more important to the medical profession than the smaller anomalies in style and title is the embarrassing fact that only those who graduate in medicine at one of the universities bear by academic right the style which is popularly granted to all medical men—viz., the title of Doctor. The diplomates of the Royal Colleges and the Licentiates of the Societies of Apothecaries are not able to style themselves “Dr.,” though the public will not allow them to describe themselves otherwise. This is extremely galling for the diplomate, as the public cannot comprehend his not possessing the title by which it prefers to address its medical adviser. The public is apt to regard the holder of a diploma as an inferior man. Hence a never-ending subject of discussion among medical men and hence a position which must come within the scope of reform soon. “The man’s the gowd for a’ that” is more undoubtedly true about the practitioner in medicine than about the member of any section of the community, and many a man possessing only the pass title of his corporation enjoys a position every whit as good socially and scientifically as his colleague who is a medical graduate, but this does not alter the fact that the classification into “Dr.’s” and “Mr.’s” of the rank and file of the medical profession does a real injustice to a great number of men, especially to the London medical student whose peculiar position should be considered.

Twenty-five years ago the average annual entry of medical students intending to take out their whole curriculum in one of the twelve London schools was little short of 700. It varied from 670 to 730, and to these there had to be added a fair number of students who, having done their preliminary work elsewhere, joined a London medical school to complete their course by "walking" a London hospital. During the "eighties" and "nineties" the common entry of general students at all the schools gradually dropped; now one school and now another appeared to suffer more than its fellows, but the story was one of regularly decreasing popularity of the London schools. Dr. J. Kingston Fowler, the dean of the medical faculty of the University of London, who has made the position of the London medical student his particular care, has recently given, upon the authority of the several deans of the schools, 424 as the annual average number of medical students entering for the whole curriculum in London during the period 1900-04. The broad significance of the desertion of London by the medical student must not escape us. London is not only the capital of this country and this empire, but it is a truly world's capital in a way and to an extent that Paris and New York are not. If, as would appear incontestable, medicine and surgery can only be learned where men and women are congregated together in sufficient density to display numerous types of disease, then it follows that London should possess the first medical school in the world. An unexampled wealth of material should be utilised by the finest processes of tuition, or the world is

deprived of what it has a right to expect. When a medical student turns his back for choice upon London and seeks his education elsewhere, when the famous hospitals of the metropolis do not attract him, when to reside at the world's head-quarters appears to him to offer no rewards commensurate with its drawbacks, a serious position is implied. By so much as the work done in the wards and out-patient departments of the London hospitals is not utilised for educational purposes, by so much is our country placed at a disadvantage compared to others—we are wasting scientific opportunities. The world is the poorer and Great Britain is especially the poorer. The advantages of living in London and the field that is offered by London for the observation of disease cannot have escaped the attention of the student or his parents. A huge seaport, the seat of a court and a Government, a teeming industrial centre finding employment for tens of thousands of operatives, a fashion and pleasure capital, a focus around which 20 residential cities are more or less loosely grouped, and the money exchange of civilisation,—that is London, and such a city, or rather such a congeries of cities, must have within its ill-defined ramparts examples of all sorts and conditions of physical ill. Before the student of disease would turn his back upon the opportunities thus offered to him he must feel that he would suffer in London from disabilities so serious as to annul the benefits.

The fact is that medical education in London is in a displayed and confessed condition of disorder; the disorder is made worse by the shortage of

medical students and consequent pecuniary loss to the schools: the London medical student cannot secure a medical degree upon terms which obtain elsewhere, though its qualifications for a degree are undeniable. How far these things depend upon one another is not as unquestioned as is the existence of the condition, but the connection is undoubted. There are in London twelve medical schools, each complete in itself and all offering to teach the medical student everything that he requires from the beginning to the end of his curriculum. Each school possesses, in addition to lecturers upon, and demonstrators of, anatomy and physiology, teachers of all the ancillary subjects, and each has striven to provide the necessary laboratories and class-rooms for such an undertaking. Fifty years ago, the scope of the medical student's education being what it was, a medical school attached to a metropolitan hospital could easily provide all the necessary educational facilities for a student; twenty-five years ago the twelve separate schools were working fairly satisfactorily as separate institutions, although those few persons who considered the matter outside their own immediate interests were able to prophesy imminent trouble. But since 1880 the expenses of medical education have been enormously increased with dire results to all this subdivision of effort. The development of physiology, the recognition of the intimate connexion between practical chemistry and biology on one side and pathology on the other, the increase of our familiarity with electrical phenomena—these and many other advances in our scientific knowledge will occur to the mind at once as involving a medical

school that would aspire to be completely equipped in grave expense. All the London medical schools responded gallantly to the calls made upon them by the progress of modern medicine; some were enabled to do so much more completely than others, but the story has been on every side one of unselfish profusion. The medical education of England had, to a great extent, been confided to the London medical schools and the men responsible for those schools made strenuous efforts, and for some time with no mean measure of success, to meet the demands upon them. But it has of late been borne in not only upon the authorities of the smaller medical schools but upon many connected with the larger schools that it is useless to continue to struggle for the maintenance in London of twelve separate centres of medical education. (See Appendix § ii.)

Several of the larger hospitals might be able to maintain themselves as individual centres but amalgamation was seen to be the right course for the smaller schools. To support in several places upon money that could be ill-afforded, a laboratory and a class-room for the instruction by an unpaid teacher of a small group of lads was seen to be hopelessly uneconomical, when one teacher in one class-room could be paid to do the work properly. And as the numbers of the London students began to drop off this position became clearer. At first it led to increased expenditure by the smaller schools in the idea of attracting more students whose fees would justify the cost to the school—and in some cases to the hospital—of provision for an up-to-date education; but lately the futility of this course has

been recognised. For lately, owing to several things but chiefly to the reconstitution of the University of London, whereby the medical schools of the metropolis became affiliated to the University, the position of the London student became better understood. It became recognised that to a great extent he was not deserting the London schools so much because he found the teaching in them inadequate as because for several reasons it was very difficult for him to obtain a medical degree.

Immediately the subject of a medical degree for the London student is mentioned we are confronted with the dilemma that there is a medical degree available for him and for the rest of the empire—that of the University of London. “Why,” asks the partially informed man, “does not the London medical student take advantage of what is offered to him?” Or, regarding the matter a little differently, “Why should the standard of the London degree be lowered that the London student may be able to pass the medical tests?”

It is true that the degree in medicine of the University of London is of a high standard—probably when every branch of medical learning is considered with the examiner’s eye the London degree is the best medical degree in the world. But it has not been wholly the intellectual difficulty of obtaining the degree that has kept the London student in greater numbers from competing for it—the fault has lain also, and to an extent that has not been realised, in the absence of any systematic teaching for London medical students directed towards their obtaining the London degree. The twelve schools

were strong, some of them, in one direction and weak, some of them, in others. In one school the dean, seeing the paramount value of a medical degree, would exhort the student to obtain it; in another school the dean might not be over-interested in that matter or, indeed, in the students generally. The matriculation at the University of London undoubtedly was an obstacle to many students. This is still a test examination offering considerable difficulty to a lad on the threshold of a professional career, but the examination has now been made more reasonable in scope and design and should offer no insurmountable barrier to the properly taught student. And if he has some difficulty in the beginning of his career that is where difficulty should come, for the proper grounding that is insured by a searching, but not unduly hard, examination at the beginning serves the student an excellent turn later. A good general knowledge, which may be elementary but must be sound, of the preliminary subjects makes the rest of the curriculum so much simpler that the fortunate student who has begun by passing a fairly rigorous test can never understand the trials and vexations that seem to await his contemporaries at the hands of their examiners. At the University of London, after passing a distinctly high grade of matriculation, the student finds himself confronted with a preliminary scientific examination which, again, is of the nature of an honour examination. Here the well-grounded candidate should be ready for the fray, but no soldier, however good, can fight effectively without weapons. And some of the London medical schools have not until recently provided the proper

facilities for passing the examination. There is not a school in London, and there never has been, where an intelligent student of rather exceptional industry, bringing method to bear upon his work, could not pass the examinations for the London degree, but every student is not by nature orderly and industrious—nay, more, he may possess neither quality as they are understood by examiners and yet possess them both in a high capacity as a practical man for the practical issues of life. (Be it understood that examinations, whatever their purpose, are not necessarily practical and that the medical examinations of the University of London are, and have been, in no way distinguished for their practical character.)

These facts put a different construction upon the comparative failure of the London medical student to graduate in medicine at his University. The elements of chance have played a great part in his career. His school may not provide the necessary facilities or teachers; his classes in special subjects may be so small that the stimulus of competition may be much absent; his curriculum is not mapped out for him with a medical degree at the inevitable end; on the contrary, there are alternative tracks along which he can reach the Medical Register. All these things are obstacles to a smooth career, and though they are frequently surmounted by young men possessing no vast claims to mental superiority, still—now one, now the other, now all combined—they prove fatal to the efforts of many who in a more favourable environment would be able easily to satisfy intellectual tests similar to those of the

University of London. It is a partial view, therefore, that regards the fact that a great many London students do not obtain a medical degree as a necessary reason for demanding the lowering of the standard for obtaining that degree. The truth is that medical education in the metropolis at the present moment, in spite of much excellent individual effort, is an ill-arranged affair which requires consolidation and simplification.

The public, as well as the medical profession, has lately had a chance of seeing the situation clearly, for it was brought into considerable prominence at the beginning of this year by a valuable report made to King Edward's Hospital Fund for London by a small committee consisting of Sir Edward Fry (chairman), Lord Welby, and the Bishop of Stepney (Dr. Cosmo Gordon Lang). This committee was appointed by King Edward's Hospital Fund for London in response to a growing feeling that money might be diverted from the objects for which it was intended if hospital authorities, choosing to consider their hospital and its attached school inseparable bodies, should make up the deficiencies in the school accounts out of money received for the charitable institution. The terms of reference to Sir Edward Fry's committee were very simple. The members were asked to consider and to report whether any money given or subscribed for the relief of the sick poor to the twelve London hospitals having medical schools is used directly or indirectly by all or any of those hospitals for the maintenance of medical education. The arrangements of the hospitals existing in January 1905, were to be taken as the subject of

the inquiry, and the committee was asked also to report, in the event of any hospital subsidising its school out of money properly belonging to the hospital, whether the hospital received an adequate return for such subsidies. The committee got to work with commendable promptitude, being a small and thoroughly competent body with definite issues before it, and made its report in a few weeks. The report found that two hospitals only out of the twelve large general hospitals of London possessing medical schools could be acquitted of the charge of subsidising their schools out of hospital funds; that two medical schools could not be ascertained to be clearly deriving any pecuniary benefit from their associated hospitals; and that all the other eight medical schools directly or indirectly received contributions from hospital funds. With reference to what repayment was made by the medical schools to the hospitals for their subsidies, the committee reported that no return was ascertainable from the schools, which could be held to recoup the expenditure of money upon pathological and bacteriological laboratories, though it was allowed that the schools supplied the hospitals with a valuable amount of skilled gratuitous service. Finally, the commissioners added to their report the following paragraphs which are only loosely related to the terms of reference but which are of the greatest value as showing a sound appreciation of the position of the London student.

“ 25.—We have formed the opinion that a broad line of distinction ought to be drawn between the studies of the first three years of a

medical student's curriculum and the studies of the last two years—or, in other words, between the preliminary and intermediate studies on the one hand and the final studies on the other; and that whilst the latter studies can only be pursued with advantage within the walls of a hospital and nowhere in the world with more advantage than in London, the earlier studies have no real relation with a hospital and are therefore more properly to be pursued in an institution of a university character; and further, that the attempt of many of the hospitals to associate with themselves schools teaching the preliminary and intermediate subjects is a great, if not the chief, source of the exhausted condition of the funds of many of the schools and of the consequent demand of the schools on the funds of the hospital.

“26.—It is therefore with great satisfaction that we find that the statutes of the University of London (Paragraph 80) direct the Senate to ‘use its best endeavours whenever practicable to secure such common courses of instruction for internal medical students in the preliminary and intermediate portion of their studies under appointed or recognised teachers at one or more centres’; and if this object can be carried into effect we believe that it will free some of the schools from burdens which they find it difficult to bear.”

These paragraphs were seen at once to strengthen enormously the hands of those who believe that in the reconstitution of the University of London lies

the salvation of the London student. A central school at the University, or two or three central schools founded as integral parts of the University, would secure for the London student proper education in all the preliminary parts of the examination. He would be taught by well-paid professors in well-furnished laboratories—he would, in short, enjoy a proper educational training, well organised, and well directed to a definite end, as does his brother student in Liverpool or Edinburgh.

The efforts of the present teachers of the introductory and ancillary subjects in London must not be despised any more than must those of a small hospital, desperately short of money, which founds and tries to support all the machinery for a modern scientific medical education at the cost of, say, £5,000. The hospitals and schools of London have struggled manfully to deal with the situation. They have strained their resources—one or two of them to snapping point—in their endeavour to fulfil their proud functions of the past and their lecturers and demonstrators have gallantly seconded their efforts by doing admirable unpaid work. But the students are not attracted, and without the students the struggle cannot and need not be continued.

The common experience of those who have interested themselves in the London student, no less than the report of Sir Edward Fry's committee, shows these three things and we have to make up our minds to what degree they are inter-related. We have:—(1) a decided falling off in the numbers of the London students; (2) a system of medical education that is manifestly faulty as well as uneco-

nomical; and (3) undoubted difficulty in obtaining a medical degree in London. Cannot all these three things be related so that if the University of London can provide the proper scheme of education the students will return to the London schools where the best clinical material for their later studies may be obtained? And would not the degree of the University of London be secured by a good proportion, say 75 per cent., of the students when they receive proper teaching to that end? I believe so, and I do not attach great importance to the cry that a medical degree for London students implies the lowering of the standards of the degree of the University of London. With considerable disadvantages the London medical student as a rule takes the diplomas of the English Conjoint Board, and we know that this final examination is of a really high character. Those qualified by the Board take good places almost invariably when they enter for competitive examinations; and the number of men who, possessing the double diploma of the London Conjoint Board, reach high positions in private practice and in public appointments is great. These things go to show that the want of a medical degree for the London student is an accident due to faulty arrangement, but an accident which may militate so seriously against his future career as to have decided many students to seek their medical education elsewhere than in the metropolis. Many hospitals—London and provincial—all the important ones in fact, have laid it down that their medical staff shall be graduates in medicine. The mere diplomate, though he may be known to have passed an examination that would have

amply secured for him a doctorate at centres other than London, cannot compete for posts at hospitals against the holders of medical degrees of any sort. And in private practice he is liable to be told that whatever the people may call him he is not a "real doctor"—which is a genuine grievance.

The question is: Can the newly constituted University of London come effectively to the rescue? There is no doubt that the Faculty of Medicine of the University has done its best to meet the case. When the Senate of the University came into office it recognised the obligations imposed upon it by statute and requested the Faculty of Medicine to consider the position of medical education with a view of reform. The Faculty of Medicine consisting of some 400 recognised teachers, many of whom are connected with the London medical schools, appointed a committee from which it received an important report. The gist of the report can be realised from its result, for a movement was at once inaugurated for the foundation of an Institute of Medical Sciences to serve as a central school for the education of the students of the University in those subjects the study of which must precede professional study proper—which latter would necessarily be undertaken at a hospital. An appeal was made to the public, signed by Lord Rosebery, the Chancellor of the University, and all the chief officers of the University, begging for the immediate support of an Institute of Medical Sciences. This appeal was received by the whole of the press of London with outspoken approval and met with a prompt return, several munificent donations being received. Subse-

quently a letter, signed by the treasurer or chairman of every London hospital concerned, was addressed to the Chancellor of the University endorsing the action of the Senate. All these important and responsible officials, who had been compelled by the positions which they held in connection with the general hospitals of London and their medical schools to give the proposal that the University should undertake the teaching of the preliminary scientific subjects of the medical curriculum the most serious consideration, had come to the same opinion. They were convinced, and had no objection to saying so publicly, that the adoption of the recommendations of the Royal Commission in favour of the concentration of the teaching of the preliminary subjects had become a matter of urgent necessity in the interests alike of the hospitals and the medical schools.

This opinion is not held unanimously by all London medical teachers; certain of them consider the plan of fusion of all the schools into one central institute, as far as the purely school subjects are concerned, to be a mistaken policy. They admit that the smaller schools depend for their very existence upon some amalgamation scheme and think that these schools might well enter into a form of combination among themselves for courses in the non-professional scientific subjects, leaving anatomy and physiology still in the hands of each hospital school. The larger schools, they consider, being affiliated to the University of London, might be helped by the University with any money that the University can raise for educational purposes, but it seems in their opinion unwise to dissociate all pre-

liminary science teaching from the teaching of the purely professional subjects, which must be taught at a hospital. The opponents of a scheme of centralisation use the argument of economy every whit as keenly as its advocates, for they point out that much money has already been spent upon perfecting the medical schools of the various hospitals, while much more money is yet required before the Institute of Medical Sciences becomes a possibility. But the wastefulness of removing the study of the preliminary sciences from these numerous newly constructed institutions is not as great as it looks. Annual subsidies from the University to the different efficient centres would mean year by year a set of separate smaller payments that would in the aggregate amount to more than the one set of large payments necessitated by a central institution, while many more chances of maladministration would be introduced. Again, the money already subscribed for and spent at the separate medical schools will not be wasted entirely, or even at all. The laboratories, intended for the pursuit of physiology and chemistry, can all be employed for those sciences medically applied—*i.e.*, for pathology. There is great and immediate need in London for improved clinical and pathological laboratories if London is not in this respect to drop behind the provinces, for everyone recognises as the most salient characteristic of modern medicine its association, through pathology, with chemistry and physiological chemistry, an association which grows momentarily more intimate. None of the money spent on bringing medical schools up to date will be wasted. The laboratories

can simply be used to supply other needs that are very severely felt. The huge size of London is an argument against making it compulsory upon all students to attend one place and one only, but there might be one Central Institute of Medical Sciences at the University of London and two others, perhaps, auxiliary to it; there can be no doubt, however, that economy will be best served by the concentration of the science teaching of the medical student in one, two, or perhaps three centres.

These things have occurred of course to the minds of the Senate of the University of London, for this body has lately appointed a committee to confer with representatives of University College, London, and King's College, London, and of the schools of the University in the Faculty of Medicine, as to the practicability of securing common courses of instruction in the preliminary and intermediate subjects of medical study at University College and King's College, such common courses to form part of a scheme for the concentration of the study of those subjects in the University. The wish is to utilise to the full extent the existing opportunities for concentration afforded by University College, London, as a northern centre and King's College, London, as a southern centre, while waiting for the foundation of the Institute of Medical Sciences. It is recognised that the resources of University College and King's College are inadequate to accommodate all the students at present in the London schools and for a time it will be necessary to continue the teaching of the preliminary and intermediate subjects at some of the schools. Naturally it will be the larger

schools—the schools of St. Bartholomew's Hospital and London Hospital, for example—that will remain for some time unchanged, and it is at these schools that permanent resistance to a complete centralisation scheme may be expected. Every school naturally resents being forced into a centralisation scheme, and the large schools, where as yet no urgent necessity presses for the strength that comes from union, may well be expected to make a fight for individuality. Conscious of having done their work thoroughly well, they do not see why they should give up doing it, and the feeling is one with which we must all sympathise.

But the interests of the London medical student demand amalgamation. The larger schools may say that it is not the inefficiency of their teaching that has caused the dearth of students; but rather the facilities offered by other medical centres for attaining a medical degree. To this the reply is that equal facilities can only be obtained under an amalgamation scheme. Such splendid work has been done by London teachers in adverse circumstances, and in return for little or no payment, that it would be indeed ungracious to suggest that the quality of the teaching is not what it was, but, without making any such suggestion, it is undoubtedly true that some of the best London teachers are snapped up by other medical schools and well paid by them. So that again centralisation appears as the remedy for existent evils. The bringing of all the medical students of London, at the beginning of their career, into one of two or three schools not connected with this or that hospital but forming an

integral part of the University of London, would naturally turn the student's eye from the beginning of his career upon the M.D. of London as his proper goal. All his early education would be towards that end, and being systematically instructed, he would not find the purely scientific examinations so hard as to form an unjust barrier against his legitimate aspiration to be a medical graduate of his university.

CHAPTER XIII

THE FAULTS OF THE EXAMINATION SYSTEM

The Multiplicity of Examinations.—*Mr. T. Pridgin Teale's Views.*
—*Professor F. Y. Edgeworth on Chance in Examinations.*—
Sir George Humphry's Views.—*Sir William Stokes' Views.*—
Centralisation or Decentralisation.—*The Lightening of the Curriculum.*

THE medical education of the London student has been treated separately at some length because his circumstances are not only so peculiar but also so gravely important to the community. That the clinical material supplied by the metropolis should be properly utilised is of national, and more than national importance, and that the teaching of London, possessing such material, should not be recognised by students as among the best teaching of the world is lamentable. But there is reason to hope that the London schools have touched bottom, and that we may soon see them restored to their former proud position, aiding as they should in the educational developments that are imminent in the near future. For the medical curriculum, as it at present exists, does not defy criticism, it does not even escape blame, even though it be in all intents and purposes uniformly arranged at the different centres and be

watched over with undeniable vigilance by the General Medical Council. The Council itself has now become restless in respect of its educational duties, for it has become manifest that the demands made upon the students at their examinations are seriously interfering with their clinical studies. As we have seen, the fifth year of the student's curriculum was designed to be devoted entirely to the study of hospital practice. Bookwork of all sorts, whether general (mainly preliminary) like the literature of physics, or special (mainly professional) like that of anatomy and physiology, was to be put behind the student's back. This was the project of the General Medical Council when the curriculum was lengthened from four to five years. It was recognised at that date, now fifteen years ago, that the student was required to be proficient in so many different subjects that he had not time in a four years' curriculum to make himself acquainted with all the bookwork imposed upon him by their extensive range, if he was to give proper attention to the clinical and practical side of his training—that is to say, the side of his training which, as far as the public goes, is the only one that counts. All his hours were spent in grounding himself for the reception of professional learning, hardly any time was left for the actual acquisition of that learning, and none for its practical application. Therefore the extra year of study was given him, or imposed upon him, to be devoted to clinical work. But the extension of the curriculum has not answered the expected purpose. Indeed, in the opinion of many people—and not the least observant among those who have studied the subject—the veritable

position has again been arrived at to meet which the five years' curriculum was devised.

At the winter session of the General Medical Council in 1904 this was so far admitted that when a motion was debated with regard to the arrangement of the student's work the speeches of the members showed a general belief that some modification of existing arrangements is wanted. It was made clear that owing to the increased demands made upon medical students in the earlier part of the curriculum many of them do not pass their examinations in the preliminary subjects—physics, chemistry, and biology—until after they have made a beginning of the professional section of the curriculum. This precludes the undivided attention which the study of such subjects as anatomy and physiology requires, while the fifth year of the curriculum becomes overloaded, bookwork intruding upon the practical routine. Some authorities think that the passing of the preliminary scientific examinations should be made compulsory before the admission of students to the study of anatomy and physiology, others that the student before presenting himself for his final examination should show that he has devoted at least one year to clinical work alone. A third way out of the difficulty would be to increase the curriculum by one more year, and this, it may be said, would be an increase in name only, for the average duration of time taken by the medical student to gain his entry on the Medical Register happens to be six years and one month. Against increasing the length of the curriculum there is so much to be said from the economical point that it hardly needs the saying. The medical pro-

fession is now a very difficult one to enter and if the curriculum were increased to six years' duration the education of the student for his difficult career would cost more than £1,000, while the majority of medical men would be 25 years old upon becoming qualified. Undoubtedly few men earn much money in practice before that time, but as the six years' curriculum would probably lead to a multiplication of examinations and a further increase in the average period of studentship above the statutory period, the General Medical Council, whatever it may feel obliged to say in debate out of a consensus of feeling that the student must progress with the times, will probably not sanction, at any rate for some time, any extension.

The multiplication of examinations is particularly to be dreaded and this is already being foreshadowed. There are a certain number of educational authorities who would have the student's time so divided off that at the end of each year he is examined in some one series of subjects. This puts a premium on bookwork and on the employment of coaches, and leaves the student to consider the time wasted which is spent in the out-patient department and the wards of a hospital. Ten years ago Mr. T. Pridgin Teale, who was at that time one of the Crown representatives upon the General Medical Council, called pointed attention to the danger of over-examination, and his words certainly seem now to be coming true. He suggested that the time had arrived when the General Medical Council should consider how far it could reduce the examinations of medical students in number and limit the schedule of subjects. Mr. Teale showed that during the twenty years that he

had sat upon the General Medical Council the examinations had steadily increased in numbers, while he quoted manifold evidence to prove that the element of chance played too large a part in these tests, telling disastrously on some of the best, because some of the most finely organised, candidates. He based his conclusions upon statistics of various examinations as actually reported to the Council by Mr. J. C. Miller, the late registrar of the Council. Mr. Miller's figures showed that the percentage of rejections in examinations among medical students amounted to 37·1 in the primary, 47·1 in the intermediary, and 38·9 in the final. In 1876 the percentage of rejections in the final examinations only amounted to 22, the figures showing that the more examinations are multiplied the more fatal they become. This is certainly a poor result of education, and would tend to show either that a good deal of the teaching received by the medical student is not much to the point or that the element of chance, that must always exist in any examination, becomes unfairly aggravated when every student has to pass a complicated series of examinations. For education and examination are not interchangeable terms; the examination is the test of the education, and if nearly half the students fail in an examination the education is demonstrably at fault. Such a percentage of disaster cannot be attributed to chance or to bad material, though the influence of chance in examinations is very considerable.

One of the best things ever said about examinations in illustration of their value and their limitations occurs in a paper read by Professor Edgeworth, Pro-

fessor of Political Economy at Oxford, before the Royal Statistical Society.¹ Here test examinations are compared to the “barometer, an instrument which directly measures the pressure of the atmosphere, but only inferentially, and as one sign among others, indicates that about which it is mostly consulted, the weather.” The successful negotiation of an examination proves a student to have acquired some temporary knowledge and to possess some ability for exposing that knowledge; it is one sign among many that he has been well educated or has any real efficiency. But a well constructed barometer is a better weather guide than a bad one, and in the same way a capricious examination is less a test of permanent worth than an examination where the element of chance plays no part. There is no such rigidly perfect examination, and the question of how far the workings of chance play a part in the results of examinations must always be considered. Professor Edgeworth appraises the possibility that an error of assigned extent will be committed by a competent examiner in marking a piece of work of any given sort in a most instructive and ingenious manner. Assuming that the mean of a great number of judgments constitutes a true standard of taste—and the marking of an examiner must be a matter of taste—he shows that the same hesitation which the conscientious examiner must have in assigning marks comes over the man who is asked to estimate simple objective quantities, such as the height of an acquaintance or the number of five pound notes which will balance a

¹ *Journal of the Royal Statistical Society*, 1890, vol. liii.

sovereign. And just as by observing the estimates made by a number of persons as to the weight or height of the same body the law of error can be discovered proper to similar species of estimates, so by observing the marks given by a number of competent examiners to the same piece of work an empirical law can be ascertained the working of which may be extended to similar cases. He records a number of experiments in the marking of mathematical, classical, and historical papers and shows that there are plenty of data upon which to found assumptions as to the part played by chance in the results. Referring to examinations for the Indian Civil Service, the Home Civil Service, and the Army, he finds the element of chance to be such that in any given examination the chances of displacement upon re-examination would amount to one-seventh. Judging by this figure, it is clear that we must not look to chance to account for the grave number of rejections in medical examinations, but rather to the errors of the system of training, and sometimes undoubtedly to the faults of the examiners. A rejected candidate often thinks that his examiners are very silly fellows, and is often mistaken, but a study of the questions that have on some occasions been asked by examiners leads to the view that medical students have here now and again had a genuine grievance. What is the use of asking medical students in their early examinations elaborate questions as to the comparative action of drugs when they have never seen a sick man? And what is the use of asking men in a pass examination in surgery for descriptions of rare and elaborate operations? The

fact that the candidates can describe, and presumably perform, all the operations that they may be called upon to carry out in any emergency must be elicited, but it is unnecessary to expect more of a man who has had no experience. Naturally, when in practice some grave procedure lies before him, where immediate action is not the only chance of success, he will revise his knowledge and will try to supplement it before operating; why, then, should he be rejected in an examination for not having this class of surgery at his fingers' ends?

In England, Scotland, and Ireland alike the same feeling of dissatisfaction at the examination system as applied to medical education has at different times prevailed and has found voice among some of the best known teachers, among whom may be mentioned the late Sir George Humphry, Professor Pettigrew, and the late Sir William Stokes. Sir George Humphry, one of the best clinical teachers that England has ever seen, said in a memorandum addressed to the General Medical Council upon the subject of the numerous rejections of candidates for medical examinations: "The burdening of the memory with mere facts which have no direct or obvious connection with science or practice—with facts, that is, unassociated with ideas of practical utility—is, on the whole, of little value educationally or otherwise, and such facts make but a transient impression on the memory. Laboriously crammed together, with efforts worthy of a better purpose, they are with difficulty held until the examination crisis and then quickly escape with little regret at their departure. Indeed, examination in each

subject of professional study should be restricted to the general principles and the more important facts of the science, and should be of such a character as to induce students in their preparation for it to observe and think for themselves more than is now commonly the case. The examinations should be regarded from an educational point of view, with reference, that is, to the influence which they are likely to exert upon the character, the education, and the mental training of the students, as well as with reference to their being a test of fitness for admission to the Medical Register."

Sir William Stokes, a past President of the Royal College of Surgeons in Ireland, in opening a medical session at Meath Hospital gave as follows the result of his long experience as a teacher and an examiner: "The student, wearied and weighed down by an accumulation of courses and with the sword of Damocles in the shape of an annual examination ever hanging over his head, has neither time nor inclination to do anything that, in student parlance, will not 'pay' in the examination. It seems to me that the outcome of most modern changes in the medical education is in the direction of making students read, not a few books well, but many books badly, and that the brain has been looked upon too much as an organ with an unlimited capacity for retaining, digesting, and absorbing in a given time every ascertained fact, not only of medicine and surgery, but also of all the sciences auxiliary to medicine. The attempt to carry out the arrangement is fraught with real injury to many, with disaster to some."

The gist of the words of Sir George Humphry and Sir William Stokes was the same. They found that the extension of the medical curriculum had failed considerably in its object. The extra year had been designed to be used for clinical work in the hospitals, the student, presumably clear of book-work, learning the practice of his profession—either “walking the hospitals,” to use the old-fashioned phrase, or gaining experience otherwise in practice. So much was this the intention that the Council had sanctioned a term of pupilage at the end of the curriculum to count as part of the five years and in a measure to take the place of the old system of apprenticeship. As a matter of fact, the fifth year is almost always spent by the student with his nose in his books. Everyone sees this now and five years ago it had become clear to observant teachers. The student cannot afford the time to do clinical work, or to record impressions and experiences in the wards when there is so much bookwork to be got through. The position forms a strong indictment against the habit of multiplying examinations and of splitting the subjects of the curriculum into a number of groups, and a no less strong indictment against the educational methods employed. Too much stress must not be laid upon the fallibility of examiners who in the minds of many are responsible for a part of the failure of the existing system of medical education. At some of the centres of education the examiners are chosen by the General Medical Council with great care, and at all of them the examinations are inspected by the central authority, mainly with the object of seeing that the student

obtains fair play. The arrangement by which the questions are selected is at most examination boards an elaborate one, aiming at securing a fair and common-sense test, while the student is always subjected, save at the University of London, to the attention of two *vivâ voce* examiners simultaneously, that there may be a witness, and possibly a supporter, in case he is rudely handled. Granted, however, that examinations are conducted with as much fairness as possible, the fact still remains that the medical student's career is too much embarrassed by them. He spends time that could be spent in a better way, learning by rote things that he believes will secure a safe passage through his next examination; he spends his parent's money trying again when previous endeavours have been futile; he spends his energies and his spirits; and when he gets through the examination he has swallowed, in the desperate intention of avoiding all possible chances of failure, lumps of information that he cannot digest.

There are two really substantial reasons for examining a medical student, or any other professional student, and these should always be held in view by those who have charge of his education. The first of these is to see that he is sufficiently well acquainted with the subjects of preliminary education to enable him with advantage to pass on to the study of the technical requirements necessary for him to practise the daily work of his profession. The second is, of course, to see that he has learned his work sufficiently well to enable him to practise with benefit to the public. With regard to the first, it is doubtful if the present guarantee in preliminary

education in the medical profession is a sufficient one. The standard has been much improved in recent years but it could be raised with advantage. It is at this end that the unfit should be stopped. The student who is bound to extend a five years' professional education into one of seven, or even more years, because his general education has been neglected, should be peremptorily barred at the outset instead of being allowed to struggle on, passing his subjects piecemeal, and attacking each stage of his career with all the disabilities attending an imperfect knowledge of what he has put behind him. To turn out practical medical men is, or should be, the aim of medical education. This result is not achieved by admitting all and every to the professional examinations. From such crowding comes hurry, the ever-present element of chance is unduly increased, good men meet with undue disaster, and ineffective work is done by examinee and examiner. The remedy for a multiplicity of examinations is to start with a test of proper stringency, one which insures that the persons who would inevitably have fallen somewhere by the wayside should fall at the start, and one which also ensures that the man who passes the ordeal has acquired a grounding that should make future professional tests easier.

Certain subjects are given the medical student to learn and five years are given him in which to learn them theoretically and practically, after passing an entrance examination of varying stiffness. He takes on the average over six years to satisfy the examiners of the different qualifying boards that he is up to

their standard, and their standard is regulated by the General Medical Council up to a certain point. The lengthening of a nominal five years' curriculum cannot be considered satisfactory—all the economical arguments against the statutory retention of the medical student in the pupillary state for six years can be employed with double force against a condition of things which retains him there by providing him with no proper chances of getting through his work in the allotted spell. But the direction in which to look for a remedy is not so clear as is the necessity of looking. To lower the standard of medical knowledge at a time when all around the standard of other professional knowledge is being raised would be quite unthinkable. To multiply examinations so that the student can take his subjects in many small parts, and put them behind him bit by bit is a vicious plan—the percentage of failures is actually increased thereby, and a premium is put upon unintelligent cramming. It has been suggested by Mr. Teale and others that the different medical schools should examine their own students in the ancillary sciences, but the remedy is not happy. To permit the different medical schools to examine and to pass their students in the preliminary subjects would be to court incalculable trouble, for the stress of circumstances might at any time lead to a down-grade competition between the schools. The General Medical Council could never resign to all the medical schools between Belfast and London, between Aberdeen and Bristol, so much of its discretion and authority as would be implied by allowing the schools to examine their own students in half the subjects of

a medical curriculum. Centralisation rather than decentralisation is the remedy.

First, it is necessary to secure a sound preliminary education for the medical student, as a certain percentage of rejections certainly come from the fact that a large number of candidates have not been taught how to learn. Here the General Medical Council might well insist upon more stringent tests than are yet employed, while it is greatly to be hoped that all the lads in the kingdom intending to enter a profession will soon be submitted to one form of test before entering upon their special studies. It is a fact familiar to all who have entered a profession, and more painfully, perhaps, to those who have desired to place sons in them, that there is a multiplicity of examinations which qualify for entrance. Many bodies hold examinations of this kind which, although identical in standard, are yet altogether diverse in the details of their requirements. The effects of this diversity are serious, not only to schools by rendering it impossible for boys working for the different examinations to be taught together, but also to the education of the boys preparing for the examinations by depriving them of the regular class instruction during their preparation. It would therefore be a great gain if there were a recognised standard examination the exact requirements for which could be taught in schools all over the country, and the successful passing of which would qualify a boy in the eyes of such bodies as the General Medical Council, the Institution of Civil Engineers, and so on, to enter upon the particular studies required by the examining bodies for the

different professions. The Board of Education, through a consultative committee, has recently proposed to inaugurate such a scheme, and in doing so has been assisted in its efforts by the General Medical Council. The consultative committee of the Board of Education considers that the general system of school certificates which is desirable should be granted upon examinations controlled "by a university, by a combination of universities, or by an examining board representative of a university or universities, and of the local bodies prepared to co-operate with them." The more generally representative this authority is made the better will it serve the purpose of the medical profession. If practically all medical students enter upon their special studies after passing the same preliminary examination, and that one of proper stringency, the teaching in classes corresponding to years of entry would be much easier, and the percentage of rejections would fall at once considerably.

The examination of medical men by the State for a State licence to practise is not a revolution that is outside the range of practical politics, but such a reform—for reform it is, though all the circumstances are altered since a powerful movement was first started in this direction—will take time to accomplish. The matter is discussed in a later chapter. Centralisation of medical education as far as the provision of an adequate entrance examination would be a thoroughly useful reform. Centralisation again as implied by common classes of instruction for London medical students is very desirable. But when centralisation comes to be

taken as far as the institution of a State examination for a State licence to practise, opinion is not so solid in its favour. For the present troubles some immediate relief should be found, and it will consist in lightening the curriculum wherever possible without lowering the professional standard. If the curriculum cannot be lengthened upon economical grounds, if the standard cannot be lowered for equally cogent reasons, and if a multiplicity of examinations appears to mean simply an increased percentage of failures, but one course is left open. The curriculum must be weeded of such matter as it can spare. Without in the least lowering the standard of knowledge demanded of the student upon essential points, and without relaxing any effort to make his knowledge of the more important subjects sound, all that is not absolutely necessary in the secondary subjects should be excised from the schedule. The amount of botany demanded of the student might be decreased, and schedules should limit the study of chemistry and biology in certain directions so that teaching could be employed directly upon the lines indicated. Outside these lines examiners should be instructed to attribute the greatest importance to practical work. In this way, given a sensible preliminary examination, all students of good capacity should be able to obtain their qualifications in five years, and students not so favourably dowered had better try another walk of life.

CHAPTER XIV

REFORM IN THE MEDICAL PROFESSION

A Recapitulation of Prominent Grievances.—The Organisation of the Medical Profession.—The British Medical Association.—Local Medical Unions.—Medical Defence Associations.

MY object has been to display the present state of the medical profession from a sociological point of view rather than to suggest methods of reform for admitted abuses, though in many instances the remedy for such admitted abuses has been pointed out. This has been done only when there was no doubt about either the existence of the evil or the procedure which should be used to combat it. Although the main aim has been not to inaugurate any course of action so much as to furnish material upon which action can be taken, certain obvious directions in which reform should occur immediately may now be indicated. Most of them depend upon two things. Medical union is wanted—medical combination in an intelligent and liberal form, a professional union based upon the public needs and not a trade union directed towards the amelioration of a class as against the community. And a better understanding with the public is also sorely needed. When these two things are accomplished much that is now hard and unjust in the medical life will

disappear and the public will derive advantage from medicine which it does not now enjoy.

Take, for example, the conditions of service in the navy, in the army, and in the Indian army. They can be altered at a moment's notice at the instance of the respective powers that be; all that is necessary is to convince those authorities that such alterations are advisable. Substantial improvements have been made in the conditions of employment in all three Services of late, as has been shown, and it is necessary that allowance should be made for the things that have been done when the plea for more is put forward. It is impolitic as well as inaccurate to continue to speak as if no self-respecting medical man could accept commissions in the three Services. Talk of this kind, as well as threats of boycotting, perpetuate and confirm the most unfortunate thing in the present position, viz., the social disadvantage under which the Services seem to lie. It is a fact that the recent failure of a popular service club in London has been attributed openly to the action of the committee in electing medical officers. Consider the significance of such a statement even though it contains not a modicum of truth! It stands to reason that candidates for the Services may be prevented by such stories from entering for commissions, and the lack of competition has been a very serious thing for the Services in the past. The matter is one that is not much discussed in the medical press, for many who have the dignity of the profession at heart consider that in commenting upon the exclusion from clubs of medical officers undue stress is laid upon a mere act of snobbery, but I think no excuse

is necessary for referring to it again here. The natural dislike of a young man to being reduced, through no fault of his own, to a position of social inferiority is one of the chief things that has kept commissions vacant, while the undermanning of the Services, especially of the Royal Army Medical Corps, has been at the bottom of many of the troubles that have occurred of late years. It is no answer to the objectionable action of certain clubs to say that if a medical man is a good fellow he is never left out in the cold. Every other officer is admittedly the social equal of his brother officers unless he is a very bad fellow, which is a completely different thing. The situation, however, bids fair to be altered. Lately one of the best service clubs in London, at a special meeting, revised the ill-considered attitude of a previous election which had resulted in the exclusion of the medical officers, and there is a good reason to suppose that this particular trouble is now over. It would never have occurred if the public, as represented by the army, had been in the least cognisant of medical aims and ideals, and if the spokesmen for the Army Medical Service had kept those ideals in the van of their arguments. The various directions in which the warrants might be amended—nay, should in justice be amended—have all been mentioned in the chapter dealing with the military and naval medical services, and there is not an alteration asked for that could not easily be granted. The sense of the country is all in favour of a good medical service, both in the army and the navy, and if it could be seen by the public that the civilian members of the medical profession were in

complete sympathy with the equitable claims of the service members, there would be less reluctance to reform on the part of the Government departments.

In a similar way, if the country and the Houses of Parliament could be made to understand that the difficulties of medical officers of health and poor-law medical officers in different parts of the kingdom are not only very real but form sources of danger to the community at large, those difficulties would soon receive attention. There is at the present moment before Parliament a little Bill which has the support of the British Medical Association and which has two simple objects. It would insure that none but those properly qualified should be appointed as medical officers of health or sanitary inspectors, and it would give to all such officers and inspectors similar security in their tenure of office to that enjoyed by London medical officers of health. Security of tenure for medical officers of health and sanitary inspectors, so that the public health of the community may not be dependent upon the caprice of imperfectly constituted authority, would seem at first sight to be a measure of reform about which there need be no hesitation. There need not be any confirmation in office of unsatisfactory officials and there need be no difficulty about the removal of anyone who did not do his duty. No one suggests that the cause of sanitation demands such over-protection of medical officers; but to secure the public safety it is necessary that the executive officers should have a position commensurate in some degree with the importance and responsibility of their posts. The medical officers of health all over

the country should be placed somewhat in the position which they enjoy in London—that is, they should be safe from individual spite and should be able to carry out a well-considered policy extending, it may be, over a term of years. No private interests of theirs or of anybody else should conceivably come between the public officers and their public duty. The community should see this, when Parliament would at once see it. The differences between the job work of the tradesman and the professional work of the sanitarian are not clear to the public, but surely they ought to be.

The special grievances and drawbacks under which the medical profession labours in Ireland and Scotland can be removed at once by direct legislation aimed at patent abuses, but again the necessary prelude is unanimous opinion on the part of medical men, and a comprehension by the public of the risks of the situation as at present existing. The eccentric subordination of the Scottish parish officers to a parish council and the harsh treatment of the Irish dispensary officers, who form nearly half the general practitioners of their country, are matters which require no further discussion to make clear the immediate necessity for their remedy. The Irish dispensary medical officer should have proper pay, proper pension and proper treatment as a Government officer; the Scottish poor-law medical officer should be fairly subsidised in the districts where subsidy is needed, and should be protected from parochial tyranny. The position of education in Ireland, and the warring of the two great divisions of the Christian faith, produce in that part of the

United Kingdom particular complications, and it must be recognised that the question of creed accounts for some of the difficulties in Ireland that may have only a professional aspect. It seems to me that the institution and subsidy of two new universities in Ireland would meet all the troubles due to the lack of higher education in that country. The need of a Roman Catholic University in Ireland arises from a feeling on the part of the Roman Catholics against the education of their children with the children of other faiths. The logicality of this feeling is much in dispute, but it is a strong and general one on the part of the majority of the inhabitants of Ireland and must be respected as such. The endowment of a university for the north of Ireland which, though nominally upon non-sectarian lines, would tend to become a Protestant institution must accompany the extension of privileges to the Roman Catholic community, and probably the course which would give the greatest satisfaction would be the re-establishment of the old Queen's University in head-quarters at Belfast. The educational position arising out of the mixed religions of the community has been dealt with more or less successfully in Canada. In Ontario, where the majority is Protestant, and in Quebec, where the majority is Roman Catholic, good educational standards are obtained by a dual system. Why should politicians despair of obtaining the same in Ireland?

In like manner the medical officers of the prison service and the asylum service, who have no great reason to be pleased with the terms of their employ-

ment, might be placed immediately in better circumstances. The senior medical officers in the prison service do not reach as a rule a maximum of salary amounting to £600 per annum, and this cannot be called excessive remuneration where promotion, owing to the small number of berths, is necessarily slow, and where the work is of a responsible nature. Pensions, however, are earned on the usual Civil Service scale. Medical men engaged in asylum work fall into two main groups—those employed in private institutions and those employed in public institutions. With the contracts made by the former we have nothing to do, but the latter are members of a regular public service, the conditions of which are ungenerous. The heads are well paid, but the assistants are not, and for the most part marriage is impossible for them. It is true that though poorly remunerated, they are not severely worked, and that the expectations of promotion are reasonable. But promotion is not closely associated with scientific merit, and there is no regular pension scale.

In all the circumstances so far alluded to, reform should follow immediately upon the definite action of a superior authority, whether it be Imperial Parliament, the War Office, or one of the Local Government Boards, having the desire to remove the abuse. And if the medical profession were properly organised, so that a common opinion upon many matters of medical politics were seen to be held, it would not be so difficult as it is to move Parliament or any constituted authority in the proper direction. A steady plea for justice, made with determination and moderation, and backed by incontrovertible

argument, has told already in several directions, but a unanimous expression of opinion from the medical profession would make the cause of reform much simpler. This, however, is lacking and it sometimes seems as if the medical profession were without a coherent view upon some of its most vital interests. A man may know what affects him personally in his professional life, but he seems never to appreciate that a similar thing may also affect his professional brother, while the medical men who do think about the conditions under which they work in something like a statesmanlike manner are rare. This is easy to understand, though it is none the less regrettable. Those who have few or no grievances cannot be expected to press for front places in the ranks of reform, and it happens that those who have few or no grievances are exactly those who would have most influence in obtaining redress. Those who suffer from the existing conditions have no time to make protest, or no position from which to do so influentially. They possess no individual power and absence of organisation deprives them of the power of their numbers. Isolated members of this class see the immediate evil that threatens themselves and lift their voices in protest. But they do not see the troubles of other members of their own profession, and they fail to take into account any general social factors that may be playing a part. Unbacked by any following of their own profession and unprepared with any arguments (save arguments that tell in favour of a limited class) why they should be listened to, they have no chance of effecting anything. Legislation will never be obtained for the

benefit of medical men as a class—may the repetition be pardoned me? What is good for the medical profession is good for the public, for it is to the public advantage to be served by a properly paid, properly organised, and self-respecting medical body. Demands for the redress of medical grievances on this ground will command weight, but here again it must be noted that neither the public nor Parliament can be stirred to the quick by generalities. It must be shown to Parliament that the public will be benefited certainly, and benefited primarily, before legislation will occur, and if the medical profession is to demonstrate these things it requires organisation.

The medical profession is not, of course, entirely without organisation, and there are grounds for thinking that its power for safeguarding its interests is growing. The British Medical Association was newly constituted in 1902 with the distinct intention of forming a more vital medium of union between members of the medical profession, and sufficient time has not yet elapsed to show how far this intention will be fulfilled. By the new articles of the Association the central government is kept ingeniously in touch with the whole constituency, and representatives, whose travelling expenses are paid by the Association, can make the wants of medical men in all parts of the country known to the centre. That is to say that the British Medical Association in its present shape possesses a fine fighting machinery. Take, for example, the question of contract practice. If a member of a division of the Association intimated through that division to the branch of which it formed a part, and so to the

council of the Association, that he was resigning a certain post because the conditions of tenure were unprofessional, it would be possible for the Association to ostracise all members of the Association who accepted the post which had been resigned. Again, every branch might constitute itself into a court of honour, and so a system of ethical conduct might be evolved. The British Medical Association is in short a powerful combination. It has numbers, it has a sound working scheme, and all its members are, perforce, educated people who do not hanker after trade union methods, but merely desire the fair treatment that will enable them to do their work under proper conditions. With all these advantages we are right to expect great things from the British Medical Association in the direction of reform, but the mass of members, if their attitude at general meetings may be taken as a criterion, are not yet sufficiently interested in the matter. They have, perhaps, not yet learned the powers of the body to which they adhere.

In the meantime a fair number of medical unions have been called into being with a view of establishing a consensus of professional opinion upon such matters as contract practice. Their members have perceived the conditions and the necessity for combined action. It is important that these societies should not cease from their task, although in the future the British Medical Association may be in a position to supersede them, because for the present they form the only working communication between the public and the medical profession, always excepting the General Medical Council. At the present

moment it is conceivable that the very completeness of the scheme of the British Medical Association is against its smooth working in the case of local troubles. The all-important thing in local troubles is speedy action, while the developments of the Association are towards a concentration of responsibility at head-quarters which usually leads to delay. The time may come when the branches or divisions of the Association may be so familiar with the details of medical defence, with the methods of sanitary authorities, and with the aims of medical aid associations as to be able to muster with promptitude behind an injured practitioner the full force of the Association. But at the present time this is not what occurs, and much of the work of protecting the practitioner from the effect of unfair competition has fallen upon local organisations.

In one direction the members of the medical profession can make use of the machinery that has been ably and successfully planned for their protection. There exist in the Medical Defence Union and the London and Counties Medical Protection Society means whereby medical men can secure themselves against unjust treatment at the hands of the public, while the disciplinary functions of the General Medical Council can be assisted at the same time. Each of these two bodies is excellently managed and each has met with distinct and meritorious success in championing oppressed medical men. The ease with which accusations against the moral character or professional skill of medical men can be made is well known and swiftly perceived by all with a taste for *chantage*. To read the annual report of each of

the two associations is to see how manifold are the risks which the medical man runs at the hands of the unscrupulous in the daily work of his life, while the many cases of triumphant defence prove that against organised resistance the tactics of the blackmailer are almost bound to fail. The Medical Defence Union and the London and Counties Medical Protection Society, covering the same ground in their efforts and located in the same city, would probably gain in utility to their clients by amalgamation, and such a fusion of funds and interests has long been debated as a policy that would make alike for economy and effectiveness; but, though the joint work that the two societies could do might more than double the total that they now accomplish separately, the value of their labours must not be belittled on this account. These two societies represent the best corporate attempt in the medical profession to deal with existing hardships, and the fact that they have been able to do so with a large measure of good fortune and with the approval of the public, shows how much might be achieved by corporate effort of a more general character.

One of the principal objects of the change in the constitution of the British Medical Association was to place at the service of the medical profession an institution which should combine the advantages of a local medical society with those of an imperial organisation. The probability is that in time this object will be realised, but the present is a period of interregnum and only such already existing local societies as feel that they have not accomplished their aims are likely to exterminate themselves

before seeing that the Association will be willing as well as able to fight their battles for them. There are several local societies which watch over the interests of their members with keenness and success. None of them is a particularly strong or influential body, but all have the merit of being prompt to act and familiar with the situations that may arise in the locality. I may mention, for example, the Northumberland and Newcastle Medical Association, which has secured for medical men the respectful attention of mine-owners and miners who had previously regarded them as fair game for exploitation. Reform, if the word is to imply doing rather than talking, for the present depends, it seems to me, upon the multiplication of such bodies. This does not imply the creation of a crowd of new associations. In every populous centre the medical society—there is always such a body—should be prepared to deal with ethical questions, and might be erected into an authority to decide upon professional matters. This would in no way change the character of the society as a scientific body, for the political and scientific sides could be kept apart in their working, while each would gain by the union. Thus, each section of the medical profession would become familiar with the needs of other sections, the stupidity of dissension would become patent, and the public would range itself on the side of well-founded demands for reform. Then reform would follow.

CHAPTER XV

THE PUBLIC AND THE MEDICAL PROFESSION

Bad Effects of the Want of Concord among Medical Men.—Medical Etiquette and Medical Ethics.—The Public Conception of Medical Duties.

It is an especially unfortunate commentary upon the great good which would follow upon medical organisation that at the present moment certain sections of the medical profession should be, or should so often appear to be, directly pitted against each other. There is a tendency on the part of certain general practitioners, whose grievances are undoubtedly the hardest to bear, to regard consulting practitioners and the General Medical Council, acting separately or in combination, as their natural enemies. They consider and write that the prestige of the general practitioner has been lowered because, from the many circumstances which have been narrated, his emoluments have decreased. This is a most unlucky use of the word "prestige," the only lowering of prestige that has taken place being that which must follow upon the public exhibition of professional bad feeling. The general practitioner has the sympathy of all the medical profession (of which he forms by far the greater proportion), who see him preyed on by quacks, and irregular workers in medical fields, and they are

only opponents to reform—that is, they perpetuate the bad things now existing—who represent all consulting medical men and all public medical officials as the oppressors of the general practitioner, or who suggest that the General Medical Council has no care for his wrongs.

There are unscrupulous consultants who do their calling, as well as the public, great disservice by endeavouring to remain in sole attendance upon patients who have been brought to their attention by general practitioners. Any attempt to undermine the confidence of the public or to supplant the general practitioner will surely bring the system under which the family medical adviser is wont to obtain an independent and perhaps specialised opinion upon a difficult case into disrepute. The public is so largely a gainer by the readiness with which medical men, as a rule, are willing to submit the diagnosis and treatment of cases under their charge to the critical inspection of their colleagues, that the consultant practitioner who attempts to secure a patient for himself, by replacing the family man who first introduced the patient to him, not only commits a dishonourable act but injures the public in a very direct manner. The position so seldom arises that to describe the consulting medical man as living by piratical excursions into the territory of his brethren is ridiculous, and mischievous as tending to lower the public estimate of the medical profession. The same may be said of violent diatribes against medical officers of health and public vaccinators by medical men who happen to hold no official position themselves. Undoubtedly both the medical officer of health and the public vaccinator are, by the

circumstances of their offices, sometimes placed in an antagonistic position to the general practitioner, but these are matters to be discussed temperately, with a view to their amendment, and not to be accepted in a sweeping way as proof that the general practitioner is wantonly maltreated by his fellows. The monopoly which has been created in behalf of the public vaccinators is unfortunate, and there is no reason why it should not be done away with, but to effect this arguments will have to be employed. The bald statement that public vaccinators receive fees which should be shared among their brethren cannot possibly stir any legislature to action, while not to recognise the arduous, delicate, and valuable work that is being done by public vaccinators is blind—as blind and ignorant as it is to represent all public vaccinators as overpaid plutocrats. The medical men who talk in this way, and who regard more temperate views as cowardly, are committing a serious error. At a time when there are many real and necessary reforms awaiting initiation they insult the intelligence of those who might be willing to help.

Next to union among medical men public sympathy is required. The various circumstances which conspire to press hardly in different ways upon different sections of the profession are not in the least understood by the public, who regard anything in the nature of a cry for reform among medical men either as a proof that the ranks of the profession are overcrowded or as a design upon the part of certain operatives, banded together by a mysterious tie called medical etiquette, to strike for higher pay. With respect to the alleged overcrowding of the medical

profession, the figures already given show that there is misconception on this point. There are too many medical men in certain places trying to do the same thing—that is to say, that the distribution of medical men is faulty, both as regards their economic position and as regards their public utility ; but the numerical ratio of the population to the medical profession has not fallen. And similarly it is a grave mistake to suppose that the members of the medical profession are in corrupt league to extract money out of the public, though it is not difficult to see how this conception had origin. The most evident examples of union among medical men have been the local combinations to resist the tyranny of medical aid associations and of workmen's clubs. The battle having been fought in these cases largely upon the question of remuneration, the public has been led to believe that this is the only question at issue and does not see the underlying difficulty, viz., that the lay employer—whether this be a Government department, a municipality, or a miner's foreman—frequently fails to regard medical service as in any way different from the service of the tradesman in response to a wage. This, as will be seen in a moment, is an error. There are coroners of the same turn of mind, who regard the wish of medical men to give evidence where it would conduce to the return of a just verdict as proof of hunger for a fee ; and there are barristers and even judges who consider that every expression of opinion from a medical witness must be made in deference to his retainer as an expert. Judges, barristers, and coroners give voice to these views, certain journals give prominence to them, and lo !

there is the medical profession branded as a venal association, that is ever working for its own aggrandisement against the public weal. What reform, asks the public of itself, would such a profession be likely to seek save such as would put money in its purse?

The deduction is fair enough, but it is made from an incorrect observation of facts. Medical etiquette has none of the sinister significance that it is supposed popularly to have. What, then, is it? It is the behaviour entailed upon medical men by the observance of medical ethics, and the rules regulating medical conduct are designed with a view of marking the difference between the profession of medicine and a trade. There is no need more than to indicate the distinction, for the comparison has been drawn so frequently. A profession and a trade have this in common—each is a vocation in which a man seeks to make a livelihood by serving the public. But in trade the rivals can compete for public favour by asserting that their methods of ministering to their clients are better than those of others following the same calling. They can do this without taking an unfair advantage of the public, for the public can judge whether the wares sold to it are what it wants, are up to sample, and are in accordance with advertised claims. In a profession these assertions cannot be made without a risk of deceiving the public, because the public cannot judge of their truth. The specialised work of a medical man cannot be gauged by any who have not special knowledge, so that medical men for the protection of the public have agreed not to make any public claims to skill or learning. In this way the loud pretender is at any

rate to a great extent defeated, but from this situation arises the fact that medical men must trust each other a great deal, and must maintain between each other a high code of honour. They must treat each other as they would be treated.

The public belief that medical men are guided in their behaviour by a set of quaint and secret rules, designed to maintain medical interests at the expense of the layman's purse, receives confirmation from the fact that many medical men appear to want to regulate their conduct towards each other and towards the public by some elaborate code which shall meet any professional difficulties that may arise. They do not find it a sufficiently explicit position to say that obedience to the dictates of medical ethics implies application to the ordinary chances of professional life of the rule that a man should do as he would be done by. If only medical men and the public would see that the gist of medical ethics lies in that sentence the medical attitude in public affairs would be better comprehended. Aphoristic by-laws designed to meet special cases are often useful, and it is not intended to decry the value of one or two codes of ethics that have been published, but such books are likely to mislead the professional man as much as the public if their limitations are not recognised, by causing both to think more of special instances than of general principles. Take, for example, this common situation. A medical man is in attendance upon a patient, and the patient desires to discharge him and to employ somebody else. The patient finds that there is difficulty in obtaining the service of the second medical man, who, though prepared perhaps

to assist in any acute emergency, declines to take over the case save from the hands of the previous medical man. The patient complains that obstacles are placed in the way of his obtaining the medical advice that he wishes to have, and blames "medical etiquette." His view is supported by the unfortunate circumstance that many medical men write and speak as if they believed that, having once been called in to see a patient, they had obtained a vested right in that patient, and could on no account be dislodged from his bedside. Now, clearly a patient has the right to see whatever medical man he likes, but it has been thought advisable by the medical profession, in the interests as much of the patient as of the medical man, to lay it down that a second medical man should not attend until the first medical man has been definitely discharged from the case, when the second medical man would receive from the first medical man a statement of the circumstances. The reason for this is obvious. The patient, being without medical learning, cannot know that the treatment, which is apparently doing him no good, is the wrong treatment, and cannot tell a second medical man even what that treatment has been. If the second medical man does not consult with the first, he is treating the case without being in possession of the facts necessary to make a diagnosis. If the case goes well he will obtain credit at the expense of a brother practitioner which he may not deserve, and mark—he will obtain the credit even though he repudiates its justice. If the case goes ill, it will be considered that the preliminary mismanagement of the first medical man had dictated the bad issue.

Now let the second medical man consider whether he himself would like to be placed in the position in which the patient has placed the first medical man. This is but one example of situations that may arise by the score, and most of the others can be similarly solved by the simple application of the same rule. A code-book undoubtedly has its uses if too much is not expected of it, but however well drawn up it may tend to elaborate and to obscure what should be simple, while any attempt to meet all cases by special decisions must fail. As life in general gets more and more complicated it becomes more and more impossible to lay down cut-and-dried rules to meet each division or subdivision of circumstance or emergency.

The belief that the medical profession is governed by a set of rules framed with a special design to exploit the public is blended in the public mind, to the detriment of the profession, with a very different idea. The public conceives that medical service must be in a sense a poor thing because so much of it is rendered gratuitously. The public view—at any rate the view of the poorer section of the public—of the connection of a member of the medical staff of a hospital with his institution is a comically paradoxical one. First it is thought that the medical officer is paid for his work, and here he is considered greedy to make money out of the afflictions of his fellows. On learning that he is not paid at all for his hospital services the public at once thinks meanly of his exertions, not being able to understand that good work can be unpaid work. It is not understood that gratuitous work is done by

medical men because the experience so gained is valuable to mankind, and because only in this way can material for scientific progress be obtained, every whit as much as because, without the experience furnished by hospital wards, few medical men can become great and very few can become successful. Legitimate ambition and legitimate desire to be properly paid for good work play their part in inspiring the honorary staffs of our great free hospitals, for the value of the hospital connection is realised to its full; but the desire to increase the stock of the world's wisdom and to decrease the sum of human misery, the love of science for itself and affection for the medical profession, these things also confirm medical men in their willingness to serve the sick poor without reward in money—indeed, at a vast expense of valuable time and knowledge. This is the professional conception of the situation, and it should be understood by the public.

But undoubtedly those who see in this altruism of the medical profession a confession of weakness, and who are influenced accordingly to treat the members of the medical profession as of no particular account, receive from other circumstances frequent support. For it is not only the member of the hospital staff who works for nothing, but all medical men are constantly serving the public gratuitously. The General Medical Council, which does work of paramount importance to the State, receives no subsidy whatever from the State, and has accordingly been in considerable pecuniary trouble. Again, when the country decided that the registration of midwives was necessary, machinery in the shape of the Mid-

wives Board was devised for the proper examination of candidates, for maintaining an efficient roll of the women, and for exercising disciplinary powers over them. In the constitution of the Midwives Board every precaution was taken to guard the interests of the public and to secure fair play for the registered midwife, but there was no provision made for paying the Midwives Board. The work is done for the State by busy medical men and busy public-spirited women, and should be paid for by the State. Also, under the Midwives Act the midwives are in certain circumstances required to seek medical co-operation, but the Act contains no provision for the payment of the medical man, it being apparently taken for granted that he will give his services if the patient cannot afford to pay him. She never can afford to pay him, and the medical man works for nothing. The same thing is seen throughout our social scheme, the same very flattering but very embarrassing reliance upon the generosity of the medical profession, and so much has it become the spirit of medical men to give their work away that even such a protest as I am now making will be voted vulgar and "tradesman-like" by some superior spirits. Yet why should a medical man be expected to sign dozens of gratuitous certificates? School boards want certificates to explain the absence of their scholars, sick clubs want certificates to guide them in making allowances to their members, life assurance offices want certificates to assist their regular officers to estimate risk; in the last case a minute fee is usually proffered by the office when it is not possible to make the proposer for a policy pay; in the other cases the work is done by

the medical profession for nothing. Sometimes the filling up and signing of these certificates wastes a serious amount of time and involves considerable writing. All such sick certificates should be paid for, either by the persons who want to show them or by the persons who insist upon their being shown. It would be logical to go further and say that death certificates should be made the subject of a fee to medical men. There would be in some respects difficulty in supporting this claim, but we may be perfectly certain that nobody but a medical man would ever be expected to give death certificates for nothing. The copies of them, which are not made by medical men, are subject to a fee.

In all public affairs parsimony towards the medical man exists. The scale of remuneration of medical witnesses is ridiculously low. This is acknowledged by everyone, but as yet there has been no remedy. Municipal bodies, whose spendthrift policy in every direction is notorious, frequently attempt to get their official sanitary work done on the cheap; a certain class of coroner delights in dispensing with the attendance of a medical man at inquests, alleging with perfect gravity his position as guardian of the public purse in extenuation of his recklessness. Yet, surely, anyone who thinks must see that the cause of economy is not really served by making the busy medical man unable, save by fining himself a substantial sum of money, to give evidence in a law court, nor by sweating the man on whom the public health of the community exists, nor by increasing the inevitable percentage of unjust verdicts delivered by coroners' juries. Not long ago it was proposed in a

certain rural sanitary district that measles should be raised to the dignity of a notifiable disease, when the rural council in a light-hearted manner resolved to call upon the medical men of the neighbourhood to notify all cases occurring in one household for one fee. The first idea of the authority, in making a proposal believed to be for sanitary progress, was to save a part of the money due for the sanitary assistance of medical men! Why should the first idea of a public body planning a development under an Act of Parliament be to invite the medical practitioners of the neighbourhood to break the law, with the view of receiving smaller fees than Parliament has awarded them? Why? First, because it is ingrained in public bodies to try to get medical assistance for nothing; and, secondly, because the public, knowing nothing whatever of the details of medical life, believes that an epidemic of measles brings a fortune to the medical men of the neighbourhood. Medical men in a rural district do not make money by the prevalence of measles; on the contrary, an epidemic may leave them out of pocket. Their work is enormously increased, but the remuneration, though in the aggregate larger, does not keep pace with the increased expenditure. This is not a theory, it is a fact, and one that it would be just of the public to remember.

I will give one more example of popular misunderstanding of the position of a medical man. It frequently happens that a medical man cannot come to a patient when he is summoned. Sometimes he is under an engagement to go elsewhere at too short an interval, sometimes he is too fatigued,

sometimes he declines to come unless his fee is paid. If, unfortunately, the patient dies, a coroner's jury almost invariably censures the medical man, the coroner frequently allows them to do so without protesting, and many newspapers, especially those that are conspicuous for printing the indecent advertisements of quacks, join in denunciation of the "callous doctor." In a moment a citizen who perhaps does more work for the public than anyone else in the community, and does it at a low rate of remuneration, finds, to his bewilderment, that the simple exercise of his right to abstain from attending a case has earned him the reputation of a Nero in the neighbourhood. The rider of an ill-informed jury charges him with gross inhumanity in not attending the patient, or holds him up to odium because he wanted to be paid for his onerous services. Yet if members of the public would only think they would detect the gross injustice of such a proceeding. Where to do so is a matter of real urgency the medical man goes, if possible, wherever and whenever he is summoned, and it is a distinct hardship upon the medical profession that the contrary opinion should be held. Although a large proportion of a medical man's practice is unpaid, yet, when it is made clear to him that he is wanted to stand between death and a fellow-creature he goes. He does not think of his fee, he goes. He does not think of his convenience, he goes. But where the imminence of the case is not made clear he does not necessarily attend without a fee. It is not only unfair to expect the reverse, but—and this is the point on which emphasis should be laid—it is unfair to those of the

community who do pay their medical man that he should be at the beck and call of those who do not. A medical man has rarely any spare time, and every extra visit made means a visit the less in some other direction. When a witness at an inquest tells of "a cruel doctor who wouldn't come until his fee was paid down," inquiry (which is so rarely made) would almost invariably elicit that the serious nature of the case had not been made clear.

It would not be difficult to continue to give instances showing that the medical profession does not obtain fair play at the hands of the public, but I think it may be taken as established that such is the case. The medical profession is very much misunderstood by the public, and it seems to me that no effort should be spared to alter this state of affairs. The formation of local medico-ethical societies, as was suggested at the end of the preceding chapter, appears to be the best way of arriving at the solidarity of opinion that must necessarily be a prelude to any real and substantial reform. When ethical affairs are made the subject of discussion at the meetings of such societies, the debates would afford an opportunity of clearing up many points of difficulty, and of removing many causes of friction between the medical profession and the public, if members of the public were invited to be present and to speak their minds. On nursing questions, on questions of hospital administration, on such social questions as the promotion of temperance and the prevention of racial deterioration, medical men and laymen constantly confer, and with mutual advantage. The assistance of laymen at debates upon questions of professional ethics

would be useful; the good feeling evinced by such invitations would certainly be very valuable.

If the first step towards the reform of the admitted abuses in the medical profession is the establishment of solidarity among medical men, the second is the establishment of confidence between the medical profession and the public. When these two consummations exist reform will be imminent.

CHAPTER XVI

THE AMENDMENT OF THE MEDICAL ACTS

The Reconstitution of the General Medical Council.—The One-Portal System.—The Legal Prohibition of Quackery.

MEDICAL organisation, however perfect, and public opinion, however sympathetic, will not accomplish the removals of all the evils that have been displayed. They would do a great deal and would pave the way for more, but the law of the land expressly permits a state of things which cannot be altered by any united effort on the part of medical men, be it ever so kindly received by the people. As long as there are over twenty ways of entering the medical profession, so long will there be a certain amount of disorder in medical education and jealousy in the ranks of medical practitioners; and as long as the only existing legislation against quackery is limited to the imposition of a small fine for falsely pretending to be a medical man, so long will the charlatan run riot amongst us. As both the disorderly condition of medical education and the impunity of quackery depend upon the wording of the Medical Acts, it is not surprising that all medical reformers have put in the front of their programme the amendment of these Acts. The suggested amendments are usually as follows: (1) the alteration of the *personnel* of the General Medical

Council so as to make it a more representative body ; (2) the institution of one State examination by which the medical profession must be entered ; and (3) the legal prohibition of medical practice by persons not registered as medical men. They may be considered in that order.

1. THE ALTERATION OF THE PERSONNEL OF THE GENERAL MEDICAL COUNCIL.

The General Medical Council, as the Council is at present constituted, is not representative of the medical profession. It has been generally assumed that, if its constitution were altered until the Council was more representative in character, its deliberations would be of a more practical sort, while, its intimacy with the troubles of the general practitioner being greater, it would be more capable of bringing public needs into line with medical service, and of interpreting professional views so that laymen would recognise their justice. These things and more have been assumed on apparently good grounds, but it must be remembered that until a reconstituted Council has actually taken over the work to be done assumption is all that we have to go upon.

The General Medical Council, whose constitution and duties have been generally described in the first chapter, is at present made up of 32 persons, five of whom (three for England and one each for Scotland and Ireland) are elected by the registered practitioners resident in the different countries, and four of whom are nominated by the Crown, the remainder being chosen by the governing bodies of the universities and corporations, the medical tests of

which admit to the Register. The universities and corporations enjoy, therefore, a very powerful position. In many directions their interests must be identical, and where those interests clash with the interests either of the medical profession at large or of the public an effective combination could be made to uphold the teaching bodies. Such an abuse of position is not as likely to occur as some would have us believe, but the question is whether it can be made a complete impossibility. The numerical ratio of Crown members and direct representatives to that of the representatives of the universities and corporations can be raised either by adding to the former or subtracting from the latter. But there are valid objections to either course. The General Medical Council is, in the opinion of good judges—persons who have been influential members of the Council—too large already. The deliberations of the Council are hampered by its size and the expense of the sessions is increased. But, conversely, to take away from any of the universities or corporations their right to a representative is a serious step. The British Medical Association has prepared a Bill for amendment of the Medical Acts, in which this course has been adopted in a drastic manner. The examining bodies are to send only nine representatives instead of 22. The University of Oxford and the University of London, the University of Cambridge, and the University of Birmingham, Trinity College, Dublin, and the Royal University of Ireland, the University of Edinburgh, and the University of St. Andrews under this scheme are to be bracketed together and alternately disfranchised, while the representation on the Council

of the corporations is to be curtailed still more rigidly. The number of direct representatives is to be increased from five to eight and a dental representative is to be added. In this way the number of the members of the Council is changed from 32 to 23, while the representatives of the examining bodies can be put in a minority by unanimous action on the part of the Crown members and the direct representatives. The attempt so made to reduce the numbers of the Council is a brave one, but the deprivation of certain examining bodies, though only temporarily, of their votes is a step so serious that it must provoke grave opposition. To take the educational function of the General Medical Council into consideration alone, it would be clearly inadvisable that a debate should be held upon the educational standards of a university or a corporation without there being present at the Council table a representative of the body in question. On the other hand, to increase the General Medical Council until a combination of the representatives of the examining bodies could not outvote the rest of the Council would mean adding twelve more members at least as Crown representatives or direct representatives. And addition could not end there, for the examining bodies tend to increase in number—the University of Birmingham, for example, obtained a representative in 1903 and Liverpool one in 1904, while the University of Wales, the University of Leeds, and the University of Sheffield will presumably have the same privilege granted to them shortly. Each such addition must be counterbalanced if the chance of abuse of power on the part of the educational bodies

is to be removed, and the Council would tend to become in the end an unwieldy body.

The difficulties involved in alteration of the numbers of the Council have led to the suggestion that the medical profession as a whole might be more adequately represented upon the Council if the representatives of the qualifying bodies were chosen by the vote of the members of the corporations, or by the medical graduates of the universities, instead of being delegates from the respective ruling bodies of the universities and corporations. Undoubtedly if the representatives of the educational bodies were chosen by the votes of the constituency at large, the general practitioner would feel himself much more fully in touch with the disciplinary body of the profession. He would have a vote for the election of his own representative, which is in accordance with all popular notions of reform, but there is none the less a good deal to be said against the idea. The university graduates (at any rate an ascertainable portion of them) do not ask for the privilege of voting for their representatives on the General Medical Council, while the charters of the corporations appear to vest the power of appointment of a representative on the Council in their governing bodies. Before the reform can take place these charters must be abrogated. Again, elections are a weariness to the voters, as is shown by the small number of medical men who register their votes at the infrequent elections for direct representatives on the General Medical Council. Elections also impose much trouble and annoyance upon candidates, and it would not be easy in all instances to secure the candidature

of the best man, because he would not care to submit himself to the worries and personalities of an election. It may be all in a day's work for a politician, but a medical man is not inured by his professional life to being called, even by implication, a time-server, an anarchist, or an idiot, which might be the fate of any candidate who happened to seek election to the General Medical Council at a time when medical opinion was divided and feelings were running high. We have only to refer to the incidents of the election for direct representatives in 1901, when the registration of midwives was the topic upon which professional opinion was divided, to feel certain of this. A large section of the medical profession at the time was bitterly opposed to the suggested legislation and the amenities of debate were considerably strained by the champions of either side. This acrimony could be caused again by the public discussion of many topics of politico-medical or ethico-medical interest, and a series of elections might come to mean a series of rows. Besides, it is, to say the least, doubtful whether the medical profession would be better served if the representatives of the various examining bodies were to be selected by the whole constituency. Such a body as the Council of the Royal College of Surgeons of England, for example, is sure to be represented under existing methods by a tried and capable official—a past examiner familiar with educational theory and routine, a man who can carry weight among his colleagues on the General Medical Council. His qualities are known by the Council of his College before the interests of the College are confided to him. But if the Fellows and

Members of the Royal College of Surgeons of England—a constituency of 18,000 persons—were allowed to select one man among them as a representative, the chances of their choosing the man who asked most urgently for their suffrages, and who was most prolific of promises, would be great. And similarly great would the chances be that such a representative would turn out a failure on taking his seat at the Council board. I have selected the Royal College of Surgeons of England as an example, because it is a very large constituency, numbering over 18,000 governed by a very small body, which, in its turn, is elected by an upper class numbering about 1,200; that is to say, that about 17,000 members of the College have no voice in the election of their representative on the General Medical Council either directly or indirectly.

There is a way out of this position. The Council which chooses the representative might itself be elected by the 18,000 Fellows and Members and not by the 1,200 Fellows—a development that for three-quarters of a century has been urged by thoughtful people. And in a similar way the General Medical Council might be liberalised throughout. The Council of the Royal College of Surgeons of England is understood to have no serious objections to the change of constitution by which it would itself become a representative body, and at one time, a majority of the Fellows, who might be expected to wish to retain their constitutional prerogative, was actually in favour of the reform. *The Lancet* aided the movement unceasingly, and a decade ago it seemed that the members of the College were in a fair way to

obtain a share in the management of their affairs, but the untactful behaviour of a few "whole-hoggers" ruined the understanding between Fellows and Members. Relations could be renewed again if the proper course were taken. This is a very suggestive fact, for if the governing bodies of the corporations were selected by the members of the corporations then the members, as a whole, would feel that representatives appointed to the General Medical Council by such governing bodies were really appointed by themselves, and their confidence in the deliberations of the General Medical Council would be much increased. The change in the constitution of the General Medical Council that would be produced by the change in the election machinery of the various universities and corporations need not be great, but it would be a wise and good reform, because it would give the General Medical Council more the character of a popularly elected body. To proceed further in making the Council popularly elective would be to call upon the members of the profession to go frequently to the hustings, and this they would not do, nor is it certain that the best candidates would seek their suffrages.

2. THE ONE-PORTAL SYSTEM.

We come next to the proposal that all medical men should enter the medical profession after passing one State examination. The "one-portal system" has been desired ardently by some of the most liberal thinkers as doing away with all possible opportunities that some students may enjoy for entering the medical profession upon easier terms

than their fellows; and the British Medical Association has provided in its new Bill for a State examination to precede admission to the Register. The simple way of securing a one-portal system that would give satisfaction to the medical profession would be for the State to hold identical examinations in certain capitals and university towns simultaneously and to admit the successful candidates to the Medical Register under the title of M.D., or at least with the clearly specified right for each man to call himself "Doctor." As far as the public would be concerned all medical men would then be equal, and any favour which a man enjoyed with the public would be due to his work and his character. Appointments would no longer be open only to graduates of certain universities or diplomates in surgery of certain corporations. Every candidate for a post could produce as additional evidence of fitness, any testamurs that he possessed, but the non-possession of them would bar no man from competing. The London student, working in the splendid clinical field of the metropolitan hospitals with the elaborate scientific environment of a metropolitan medical school, when entering private practice would no longer find himself described as "not a real doctor" because he did not possess a university degree. All medical men would be equal in the eye of the public and the substantial grievance of the present moment that of two equally well-informed men one has and the other has not an academic right to the popular title of "Doctor," would disappear. Is there anything to be said against so simple a reform, so sure a way of making

medical education uniform, so obvious a way of avoiding a multiplicity of examinations, so complete a way out of the difficulties that have arisen from the use of the word "Doctor" as a popular style as well as an academic title? Unfortunately, there is another side to the question; the institution of a State examination for the medical profession would probably be opposed by the medical corporations. The universities might have nothing to say against the immediate adoption of such a system but the corporations would be likely to take an opposite view. A student commencing his medical career at a university would naturally desire to graduate in medicine at that university. He would pass any examination additional to the State examination and pay any fees additional to the State fees, so that he might receive the hall-mark of his *alma mater*. But the student not entering the medical profession by way of a university, having passed the State examinations in medicine, surgery, and obstetrics, and having obtained a place on the Medical Register with the right to style himself "Doctor," would have little inducement to seek from a College or a Hall any diploma. The honour diplomas or fellowships might still command candidates, but the rank and file of the medical profession would hardly consent to pay fees for pass diplomas when they already possessed the legal title of "Doctor." The corporations would probably suffer considerably, so that a one-portal system would have far-reaching consequences of a sort that must provoke opposition. And very awkward opposition, too, for the presidents and office-bearers of the Royal Colleges have a way

of being the friends as well as the medical advisers of those who make the law of the land, and an amendment to the Medical Acts which the Royal Colleges decided to oppose would have but small chance of becoming law. A final examination of all students, wherever educated, for the right to a place on the Medical Register with the title of "Doctor" has so long been the conception of the reformer that the idea cannot be given up without reluctance; indeed, it should not be given up altogether, but those who hope for it will surely have to exercise patience, for no such reform will immediately be granted.

3. THE LEGAL PROHIBITION OF MEDICAL PRACTICE BY PERSONS NOT REGISTERED MEDICAL MEN.

Such a prohibition would do away with the impunity now enjoyed by quacks and would necessitate an alteration of the Medical Acts of a decided sort. The Medical Act of 1858 in its opening clause says that the Medical Register is to enable the public to ascertain who is and who is not a *bona fide* practitioner, but it leaves the public to choose between the qualified man and the quack, merely supplying the necessary information so that the choice need not be made blindfold. The State recognises nothing but the qualified man. Only he can give a death certificate or medical evidence, or express a medical opinion of any sort that will carry legal weight. But anyone in this country can practise medicine and practise it for gain; the law will only interfere with a man who says he is a registered medical practitioner under the Act when he is nothing of the sort, or who pretends to have a

legal position as a medical man. The amount of that interference is shown by Clause XL. of the same Act, which runs as follows:—

“Any person who shall wilfully and falsely pretend to be or take or use the name or title of a physician, doctor of medicine, licentiate in medicine and surgery, bachelor of medicine, surgeon, general practitioner or apothecary, or any name, title, addition, or description implying that he is registered under this Act, or that he is recognised by law as a physician, or surgeon, or licentiate in medicine and surgery, or a practitioner in medicine, or an apothecary, shall, upon a summary conviction for any such offence, pay a sum not exceeding twenty pounds.”

It is quite clear that almost no one will ever be convicted under such a clause. An irregular practitioner has only to tell the public that he belongs to no benighted medical corporation, but is practising upon some eclectic system of his own, to escape all penalty for his action. This position ought to be altered and as public appreciation of science grows it will undoubtedly be altered; but before Parliament will sanction reform it will have to be clear to the country that restraint upon quackery is called for on public grounds. Medical men, naturally, but unfortunately, have been in the habit of regarding everything in the nature of medical treatment by unqualified persons as so productive of evil that they have a little blinded themselves to the fact that their fellow-men are free agents, free to ask whom they like to treat their bodies or their souls. A man need not belong to the Established Church because he happens to be an Englishman, nor need he

employ a registered medical man. This must not be forgotten nor must the effect of coercion be disregarded. Any attempt to make it illegal to employ unqualified men might lead to a still larger employment of them, for the public would consider the restraint imposed upon it intolerable. Members of the public have a right to consult whom they like when they are sick, even no one at all if it is they themselves who are sick and not their infant children. Yet there are good grounds for Parliament interfering with the present unbridled liberty of unqualified practitioners, and it is certain that the wiser sort of the community would welcome an attempt to do so. The misery that is wrought by quacks, the lives that are sacrificed by their lust for gain, the false hopes that are inspired by their advertisements, the hard-earned money that is wasted upon their rubbish—all these make it necessary in the public interest that a check should be put upon the nefarious practices of charlatans. In the Medical Acts Amendment Bill, prepared by the British Medical Association, there is a clause to meet the situation, which runs as follows :—

“ Penalty for practice by unregistered persons.—Any person who is not registered under this Act and who medically treats patients, or otherwise practises medicine, surgery, or midwifery, or performs any surgical operation for which he demands or receives any fee, gratuity, or remuneration, and also any person who not being registered under the Act, pretends to be, or takes or uses the name or title of physician, or surgeon, doctor of medicine, licentiate of, or bachelor of, medicine or surgery, or master in

surgery, or assumes any other style, title, addition, designation, or description, either attached to the name of the person or to his place of residence or business, or otherwise exhibited, implying that he possesses the skill and knowledge necessary for the practice of medicine, surgery, or midwifery, or that he is recognised by law as a physician or surgeon or licentiate, in medicine or surgery or midwifery, or a practitioner in medicine, or an apothecary shall be guilty of an offence under this Act, and shall on summary conviction under the Summary Jurisdiction Acts be liable (1) for the first offence to the penalty of not less than ten and not exceeding twenty pounds, and to imprisonment in default of payment of not longer than two calendar months; and (2) for each subsequent offence to a penalty of not less than twenty and not exceeding forty pounds, and to imprisonment in default of payment for not longer than six calendar months."

With this clause every medical man must be in accord, and members of the public who have realised the real dangers of quackery, its horrible menace to public health, its extraordinary depletion of the public purse, should take the same view. The clause wants certain modification, as it must be made quite clear that the ministrations of the neighbour, the nurse, or the masseur are not illegal, but with this alteration it would serve the purpose of protecting the public. It would not stop quackery, for while men are greedy there will be disgraceful advertisements, and the money of the public will be divided between rogues and the proprietors of unscrupulous newspapers. But this scandal would be lessened if

the complete impunity of the quack were lessened. The chances of fine and imprisonment would give pause to the quack desiring to claim openly "that he possesses the skill and knowledge necessary for the practice of medicine, surgery, or midwifery," and editors could not plead convenient ignorance concerning convicted quacks when the propriety of an advertisement was called in question.

But though an amendment of the Medical Acts which should prevent quackery is called for, and although to many medical men the call seems particularly loud and clear, no legislation is likely to occur without opposition. Parliament in its dislike to the appearance of granting a monopoly to any class, will require much persuasion, and even here there is wanting the unanimity of voice among medical men, the lack of which has been noted as standing in the way of so many reforms. Legislation against quackery appears to some of the most enlightened members of the medical profession unnecessary and undesirable as savouring of an undignified protection of true science. More than half a century ago, when the question of making unqualified practice illegal was being discussed, Sir Benjamin Brodie spoke strongly against the view. He urged that the medical profession should stand or fall upon its merits, as it did not require any legal protection. Things have changed for the worse since Sir Benjamin Brodie's time, yet we know that even then quackery was rampant. The dignified attitude that this great surgeon took up is one that many medical men will be found to adopt to-day, and even legislation against quackery will not be pressed

upon Parliament with the complete unanimity of the medical profession that might have been expected.

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While the majority of medical men, at any rate of those who give heed to the public relations of medicine, are in favour of amendments to the Medical Acts in the three directions that have just been discussed, it must be borne in mind that no legislation is likely to occur without considerable struggle. The reasons for the alteration of the constitution of the General Medical Council are not incontrovertible, while no alteration, it would seem, can be suggested that will not give rise to some friction among the bodies to be represented, and so prevent that unanimity of view that the public will almost require of the medical profession before any amendment of the Medical Acts receives popular support. The institution of a State doctorate, though so desirable a reform, can hardly take place without seriously damaging the various medical corporations. Anything like drastic prevention of quackery by law, though this would mean a saving in lives and money to the nation of many thousands of pounds annually, is sure to be resisted strongly when it is mooted in Parliament.

CHAPTER XVII

SOME CONCLUDING SPECULATIONS

The Sequel to a One-Portal System.—The Corporations as the Examining Authority.—A British Academy of Medicine.—An Imperial Naval, Military and Colonial Service.—A Ministry of Public Health.—The late Lord Salisbury on Moderation.

THE various defects in the professional life of a medical man, especially in the public relations of that life, have been detailed at some length, in the course of which remedies have frequently become apparent, but no systematic scheme of reform has been advocated because, on good grounds or not, I am inclined to regard such schemes as visionary. The education of the medical student may become a definite and symmetrical thing, the quack may have his soaring wings clipped, the State may find a way to provide both medical assistance for the poor and sanitary supervision of rural neighbourhoods without relying on largely unpaid work—these things, not only may, but will, happen in course of time. But I cannot conceive that any Bill proposing to amend the Medical Acts at one swoop in a wholesale manner will receive serious discussion in the House of Commons, and therefore I think it impolitic to let all measures of amelioration await a complete redress that may never come. Medical reform will arrive piece-meal and the career of the medical man will be

made smooth much in the way that an old city street is reconstructed to meet modern demands. There are here no wholesale demolition and no elaborate scheme of rebuilding. Some structures, which have become useless, are replaced by other structures better fitted for modern functions; a private house becomes a shop; a wharf is replaced by a railway station; a narrow gut by the gradual placing back of one or other side of the street is transformed into a channel of symmetrical width with the rest of the thoroughfare; a few new public buildings make their appearance; and so on—what can be used remains in use, obsolete buildings which can be satisfactorily converted to other purposes are so converted, and what is of no good perishes; but all the old associations are not violently destroyed by the crowbar and pick-axe. Similarly the medical profession, in its domestic as well as in its public relations, can be adequately reformed by the gradual removal of abuses, by the introduction of improvements that are sorely wanted, and by alterations of the functions of institutions whose efforts no longer meet the demands made upon them. There is no need for violent and wholesale reorganisation of everything, but there is every need for a common understanding among medical men as to what are the things that in the public interest most call for reform, for common endeavour to get such reform carried out, and for the enlightened sympathy of the public in the work.

It is also necessary for practical reasons that the medical profession should formulate all demands for the betterment of existing circumstances with moderation, and should recognise freely such

improvements as have taken place. To do otherwise induces inactivity in those of the medical profession who would work for the betterment of their order, while influential people outside the medical profession take leave to regard medical men as unjust grumblers, for whom it is no good to try to do more as it is not allowed that anything has been done at all. I feel that anyone who has been good enough to read these pages to their closing words might be inclined to sum them up roughly as a mass of grumbles—grumbles about money, grumbles about status, grumbles about education, and so on—but the scantiness of the suggestions that have been ventured for the alteration of the circumstances complained of should show that I have not endorsed the view that the medical profession is in a very unfortunate plight. The medical profession has steadily progressed in learning during the past fifty years—this cannot be gainsaid—while as a whole the progress has been no less marked in moral and social standing. The princes of medicine have enjoyed always the esteem and consideration of the public, but this has not necessarily been the case with the medical profession as a whole. But there are more thoroughly well-educated medical men to-day than there were ten years ago, and every decade for the last half a century has witnessed a steady levelling-up commensurate with the rise in the knowledge and culture of the public. The Latinity upon which the Fellows of the Royal College of Physicians of London were wont to pride themselves may have lost some of its finish, but this fact is surely counterbalanced by the disappearance of the apothecary-vendor of tooth brushes and perfumery.

Leaders have been lacking to the cause of medical reform who were ready with practical measures to meet existing conditions. There have always seemed to be two classes within the medical profession, those who, through apathy or selfishness, are content to take things as they are, and those who are so acutely alive to certain of the grievances under which the medical profession lies as to be unable to see or to hope for any compensating advantages. Such divisions of aims and interests have been particularly harmful in the past, but recently there have been many signs that a better state of things is approaching, for I disregard the opinion of those who affect to see in all hospital staffs and all public vaccinators the deliberate enemies of the general practitioner. At the same time the absolute necessity that medical men should themselves agree upon what is wanted before raising their voices in any demand is becoming recognised, and as much may be said for the advisability that only such measures of reform should be demanded as are plainly aimed at the public good. Moderation in what is sought under the name of medical reform does not imply any half-heartedness in the belief that such reform is required or any abstention from further demands in the future. Certainly, let medical men look forward to the time when all grievances whatsoever will be removed and when all hindrances to perfect understanding between the public and the medical profession will be swept away. This time will be a time when other professions besides the profession of medicine will be carried on upon ideal terms ; when some such perfect unanimity

between classes prevails as is usually depicted in the literature of the Utopias. Between this ideal future epoch (when, by the way, the public will need of medical men rather their advice as to prevention than as to cure) and the present day there is room for the free play of evolution, and because for the moment little is asked for it does not follow that there is but little that calls for accomplishment.

Take the one-portal system for example, the arguments for and against which were weighed in the previous chapter. It has been over and over again insisted that the institution of a one-and-only entrance into the medical profession would be a valuable reform. But at the present moment any movement towards such a reform would be resisted in all probability by the medical corporations, certain of whose functions would thus be superseded. The time will come when the corporations will be recognised by everybody to have finished their work as educational bodies. Already the competition of the provincial universities is pressing them hardly, and whereas the universities are young and will grow in strength and multiply in number there seems no particular motive force upon which the corporations can rely to strengthen their position. Professor Churton Collins has pointed out recently that a revolution, the nature and extent of which has been very imperfectly apprehended,¹ has during the last fifteen or twenty years been profoundly affecting society in this country, especially in that stratum from which medical students are chiefly drawn—the middle or lower middle class. The

¹ *The University Review*, May, 1905, "The Education of the Citizen."

tastes, the studies, and the aspirations which but a few years ago were peculiar to a small minority are now shared by the multitude. To go back a little further, fifty years ago there were in England and Wales only two universities discharging the real functions of a university—the two mediæval foundations of Oxford and Cambridge. These two universities then received annually about 2,000 undergraduates. To this total a handful of students at Durham must be added, the foundation of the University of London not being taken into account, for an examining board, however high its standards and however extensive its imperial aspirations, cannot ever be a university. Mark the difference to-day. Each of the thirteenth century universities welcomes 3,000 students as undergraduates—Oxford had 3,538 in 1904; the Victoria University has been divided so that Manchester, Liverpool, Leeds and Birmingham now contain universities of their own; Sheffield will soon be joined to this list; there is a University of Wales with three constituent colleges at Aberystwyth, Bangor, and Cardiff; while the University of London has become a genuine university with teaching functions. Scotland, which has always been the quickest of the three divisions of the United Kingdom to see the great value of popular university education, will be forced by competition to do even better than its own good deeds; and Ireland—the cockpit, where patriots fight against the well-wishers of their country and where religion flaunts the worst form of religious intolerance—Ireland presents a problem to those interested in higher education which cannot wait much longer for its solution. At

a rough estimate it is probable that where fifty years ago there were 2,000 university students working upon the narrowly specialised lines laid down by tradition, there are now some 20,000 students whose education is conducted towards perfecting them for the various higher walks of life.

The significance of all this cannot escape the many learned and able men who are in authority over the medical corporations. They must see that among the most important faculties in the new universities are the faculties of natural science and medicine, and they must be aware that as time goes on, and as a university education comes to form part of the national life of the class whence medical students are drawn, every medical student will go to a university as naturally as he goes to his bath, he will proceed to take a medical degree as inevitably as he has his hair cut, and he will be in no more need of a qualification from a medical corporation than of an Indulgence from a Pope. The corporations will then be seen to have discharged their educational functions, but it is, to say the least, doubtful if that day has yet arrived, while it is pretty certain that the heads of the corporations are not likely to respond cheerfully to an invitation to commit suicide. The one-portal system will have its chance of securing Parliamentary support when its introduction will not damage existing institutions, and when those institutions have found under altered conditions an altered scope for their activities. For the corporations will have their functions, even though the unanimous resort of all young men *in statu pupillari* to a university may make the possession of the hall-mark of a corporation

unnecessary. There is the great examining function. We have seen how important the careful examining of medical students is, and the disastrous part that is played by the element of chance in the results can only be minimised by the selection of good and competent examiners. The corporations might well provide under a one-portal system all the examiners in medicine, surgery, and obstetrics who would be required by the General Medical Council or the Privy Council. The present position of the Royal College of Surgeons of England and the Royal College of Physicians of London is mainly that of an examining body—I take these Colleges as examples because the holders of the diplomas of their Conjoint Board are so numerous and because the examinations of that Board are so admirably devised and conducted. The Colleges receive a great deal of money from students and spend a great deal of money in examining students. Beyond the support of a joint laboratory and the maintenance and preservation of the Hunterian Museum by the Royal College of Surgeons of England they do not really do much more work that is of living importance. A Member of the Royal College of Surgeons of England is as likely as anyone else on the Medical Register to be sweated by a medical aid association, to be blackmailed by a hysterical patient, or to be browbeaten by an ignorant coroner. His corporation does not attempt to take his part in any such professional troubles, but contents itself with accepting his fees and in return examining him and giving him an assay mark. If the corporations became the examining machinery for all medical students under a one-portal system it seems to me

they would be doing the same kind of practical work that they are doing now, only in still more important circumstances. In such a scheme the universities would provide the students, and the General Medical Council or the Privy Council, in looking for independent examiners, would naturally turn to the corporations. The examiners would be university graduates belonging, as the examiners now do, to the class that has aspired from the beginning to leadership in the profession. They would be teachers in the big schools and members of the honorary staffs of the big hospitals, and they would qualify as examiners by taking the high honour diploma of one of the Colleges. The Royal Colleges would come to consist of the Fellows carrying on the examination work of the country and of those graduates of universities who, intending to belong to the front rank of their science, have qualified themselves to accept examiner-ships. The income of the Colleges would be less but so would their expenses, and, in my view, their positions would be in no way lowered from that which at present they enjoy. They would represent all that is best, most ambitious, and most learned of the medical profession; they would be at once recognised as the centres of medical thought. It would be an honour to belong to them.

I do not want to be understood as prophesying exactly what will happen—no claim to such perspicuity is made—nor do I suggest that any great changes will come about immediately. My guesses at the future are so far rough that they concern principally the English Colleges. I am only attempting to show that, although at the present time the Royal Colleges

are almost certain to object to any one-portal system as taking away from them their most valuable privilege (the President of the Royal College of Surgeons in Ireland has just taken exactly this line), there is no reason why, as time goes on, and particularly as the numbers of their pass-men drop off, they should not come to regard the one-portal system as actually constituting their safety. There can be no doubt that the competition for the diplomas of the Royal Colleges, especially in England, has already abated, and this shrinkage cannot go on without being felt. A return of the medical students to London in great numbers will make no difference, for it will only be brought about by an arrangement of the curriculum that will offer the London student a fair chance of obtaining a doctorate: an accession of medical students to London will not increase the demand for the diplomas of the Conjoint Board. All the Colleges have past histories of which they may be proud. They have done, and are doing, good work—everyone allows this who knows anything about them, and the line of general abuse that is followed by some ardent reformers will never be followed by the well informed. The English Royal Colleges, for example, have placed their laboratory at the disposal of the Cancer Research Fund, and in so doing are helping in a practical way medical work of the first importance to the community.

If the numbers of the colleges go down—and some believe that the competition of the provincial universities may bring down their numbers very quickly—they may be depended upon not to let themselves die without an effort. If their rank and file

drop away they must increase the power and numbers of their honour-men and take any opportunity that offers itself for their important employment. The Fellows of the Royal College of Surgeons of England are just now largely increasing in numbers, and with improved medical education this increase may continue. But it may not, as will be seen when we look at its reason. At the present moment a man who aspires to a surgical post in many of the more important hospitals in England must possess the Fellowship of the Royal College of Surgeons of England. The number of ambitious young men has much increased of late, and consequently the number of men who acquire the English Fellowship has increased, but it is not in the least certain that this increase can be counted on for much longer. The moment that the M.Ch. of the universities is recognised, as it is perfectly sure to be, as an honour degree, the hospitals will begin saying in their advertisements that "candidates for the honorary staffs must be Fellows of the Royal College of Surgeons of England *or* Masters in Surgery at one of the recognised universities," when the competition for the Fellowship will at once disappear. Confronted with these facts the corporations in all three divisions of the United Kingdom will, I think, be perfectly willing to help on a scheme for the institution of a one-portal system; their desire will be to find a way by which their position would be confirmed as a great and important one under the new circumstances. I believe that if the examining function were given to them everyone would be pleased in time. The function would not be taken away from the uni-

versities, for all the examiners would be graduates of universities, M.D.'s as well as F.R.C.P.'s, M.Ch.'s as well as F.R.C.S.'s. The corporations would thus come to consist of the most learned and representative men—young and old—in the medical profession, and, indeed, in an automatic way, would become a sort of Academy of Medicine. Why should they not undergo this transformation? Why should not the Royal Colleges in each dominion of the kingdom be the Academy of Medicine for the country?

Now we are in the realms of imagination, doubtless, and yet this piece of evolution seems to me to follow logically and easily upon the delegation to the corporations of the examining function, while it responds undoubtedly to an admitted want. The waste of time, money, and endeavour that is implied in the multiplication of medical societies in London alone is enormous, and this fact is now being recognised by a strong movement towards amalgamation. A scheme is under the consideration of the Royal Medical and Chirurgical Society, the Medical Society of London, and other associations, designed to this end. It may be planned to serve the needs of the scientific world for many years to come, but we can none the less conceive it as only preparatory to the formation of a real British Academy of Medicine rising under the joint endeavour of the Royal Colleges and corporations. The Colleges would be the most natural centres in which a learned body—or groups of learned bodies—could hold meetings; nowhere better or more aptly could libraries and museums be housed, and the walls of the Colleges would form the natural background for the portraits of eminent

members of a British Academy of Medicine. This would be particularly the case when the examining functions of the Colleges had made the honour diplomas of the Colleges a necessity for all those members of the medical profession who take an academic view of their professional life. This is frankly an anticipation of the future, an attempt to guess to what use, when the street is remodelled, certain splendid old structures might be put so that full value could be given to their dignified past and full use could be got out of them for a utilitarian—and equally dignified—future. A guess it is certainly, but not a wild guess if the propositions are allowed:—(1) that education at a university will soon become the invariable procedure of a medical student; (2) that consequently the corporations will lose their diploma-giving privileges; and (3) that they will be found to possess sufficient vitality to live under the altered conditions.

Imagination may be allowed to range for a moment over the developments that will take place in other divisions of medical practice. Surely sooner or later there will be no need to compare the merits of the Army Medical Service, the Indian Medical Service, and the Naval Medical Service to the detriment of one or the other, but each will form a branch of an Imperial Sanitary Service the functions of which in time of peace will be mainly preventive, and the efforts of which in time of war or epidemic will be supplemented by all civilian practitioners of medicine. Of such an Imperial Service a properly organised Colonial Medical Service would form an integral

part, and every quarter of the world would show a station in which the principles of sanitary science were strictly observed and from which in time of need expert assistance could be received by the community.

Similarly there will surely be no need in a few years' time to compare the poor-law service of England with that of Ireland, or the sanitary service of Scotland with that of England. As the public becomes better educated, as it recognises how much depends upon the observance of the laws of public health, we may expect a general consensus of opinion as to the advisability of a Ministry of Public Health, the officers of which, properly selected for special knowledge in preventive medicine, properly paid, and free from any hampering conditions, may safeguard the health of the country and watch over the interests of the sick poor. The sanitary service of the country ought not to be separated from the poor-law service. They are one and the same thing, the care of the health of the sick poor implies the supervision of their sanitary environment. And the two services combined into one should be under a Ministry of Public Health, which would also relieve the Local Government Board of its responsibilities in respect of the introduction of disease from abroad, and, indeed, in respect of all relations with foreign powers as to public health.

* * * * *

As a last word I should like to quote a few lines from one of the late Lord Salisbury's essays, in which he describes the position of the holder of moderate views. He says in an essay on the position of Poland :—

“There are few positions more embarrassing than that of men who hold moderate opinions in regard to questions upon which excitement is running high. They are obnoxious to the partisans whom they have left behind, and to the partisans of whose extravagance they fall short, and are regarded by each side as combining the demerits of an antagonist and a deserter. Each party equally despises the luke-warm zeal and time-serving temper which can only take up half a cause. The pursuer of the golden mean must be content with the intrinsic value of his immediate course, he will win no sympathy and must submit to be cast out as crotchety by every enthusiastic mind.”

I feel that many who have the cause of the medical profession at heart will consider my conclusions in respect of reform to be inadequate. I shall be only too glad to learn that any more drastic measures are practicable; my moderation has not come from half-heartedness, but from a belief that the cause of reform is badly served by a perpetual bellowing for what never will be obtained. I have tried to urge the doing only of what can be readily done. But though I have been thus limited in what I have suggested as being immediately necessary for the removal of many of the disabilities of the medical profession, so as to make that profession more valuable to the public, I set no bounds to the possibilities of medicine as a profession in the future. The fact that after much complaining, after the recapitulation of a series of abuses, only a few suggestions for reform follow must not be taken to mean that a perfect condition of things will soon be reached. On the contrary, I would have it understood—for I believe

it—that the future which medicine has before it is an infinitely great one. The present disorderly state of the profession in the United Kingdom can be set aright in many particulars without any great difficulty; the men who practise under the improved conditions will be able to show a public, growing daily better and better instructed, how valuable to the community properly ordered and properly appreciated medical service may be. From this point advance should be by geometrical progression.

APPENDIX

WHILE these pages were in the press, two things have occurred which must be noted, as they show how definitely affairs in the medical world are moving towards reform. In dealing with the Naval and Military Medical Services I have called attention to the improvements in the Army Medical Service, which had begun to follow upon the Report of the Royal Commission appointed to consider the care and treatment of the sick and wounded and the management of the hospitals during the South African Campaign. A memorandum has now been issued by the Army Council showing exactly what action has been taken upon the recommendations of the former Commission. The second interesting occurrence is that a start has been made towards an amalgamation of the science teaching in the London Medical Schools, two of the smaller schools having decided to relinquish providing instruction in the preliminary scientific subjects and to transfer their students to other schools for this purpose.

§ I.—ABSTRACT OF RECOMMENDATIONS OF THE ROYAL COMMISSION ON THE CARE AND TREATMENT OF THE SICK AND WOUNDED DURING THE SOUTH AFRICAN CAMPAIGN, TOGETHER WITH THE ACTION TAKEN.

Recommendations.

We recommend the appointment at some early convenient time of a Departmental or other Com-

mittee of experts to inquire into, and report upon, the steps needed to effect the following objects :—

1. The establishment of the staff of officers and orderlies of the Royal Army Medical Corps, and its equipment on a scale sufficient to enable it to discharge adequately the duties ordinarily cast upon it in times of peace, and by the smaller wars in which the Empire, by its vast extent, is so frequently engaged.

2. Regulations and provisions which will enable surgeons and trained orderlies in sufficient numbers to be rapidly obtained and added to the ordinary staff of the Royal Army Medical Corps in the event of a great war; and that will also ensure a rapid supply of all hospital and other equipment required for the due care of the sick and wounded in such a war.

3. The attraction to the Royal Army Medical Corps of a sufficient and regular supply of officers of good professional attainments. And the improvement of the position of the officers by the allowance of sufficient holidays, and by provisions enabling them to become adequately acquainted with the advancements in medical and surgical science, and the necessity of employing in the higher posts men selected for their merits rather than by seniority.

4. The employment to a greater extent than that recognised and practised until the later stages of this war of nurses in fixed hospitals for the care of the wounded and of fever and dysenteric patients, and such others as can properly be nursed by females.

5. The appointment of properly qualified officers

of the Royal Army Medical Corps to undertake sanitary duties.

6. The improvement of the existing ambulance wagons.

7. The selection and employment of the form of hospital tents best suited for the reception of the sick and wounded in a campaign.

Action taken on the recommendations which have been considered.

A Reorganisation Committee, of which the Secretary of State for War was Chairman, dealt with the organisation of the Army Medical Service generally and delegated to an Advisory Board the consideration of certain points. This report was presented to Parliament in 1901. The following subjects have since been fully considered by the Advisory Board, Army Medical Service, and some are under the consideration of the Army Council :—

1. The establishment of medical officers has, since the War, been increased by 125, and the Establishment of quartermasters, warrant officers, non-commissioned officers, and men, including provision for South Africa, by 1,216, and the question of further increases in both categories is still under consideration.

2. The Equipment provided by the Mowatt reserves for three Army Corps, one Cavalry Division and Line of Communication Troops has been completed and is being revised.

3. By a Royal Warrant issued on the 26th March, 1902, the pay of Medical Officers was greatly improved. A college for the instruction of officers

was opened in London, and a permanent building is now in course of erection at Millbank. All officers of over five years' service are required to attend a six months' course of instruction, which includes clinical teaching in the various civil hospitals in London by civilian professors. Officers passing certain standards at the examination after the course are eligible for accelerated promotion up to a period of 18 months, and officers who distinguish themselves in selected subjects are eligible for employment as specialists with extra pay. Promotion to the higher ranks is made upon a system of strict selection based upon positive merit. As the result of these regulations the supply of candidates has been of the most satisfactory nature.

4. A Royal Warrant was issued in March, 1902, approving of the establishment of Queen Alexandra's Imperial Military Nursing Service. This Warrant greatly improved the conditions of service of nurses, and is attracting highly qualified nurses. An increase of 259 nurses has been made to the peace establishment, and this number is being recruited. The needs of all important military hospitals will be met by this addition. The scale of nurses for fixed hospitals in war has been largely augmented.

5. The appointment of properly qualified sanitary officers to all commands at home and abroad has been approved, and already in all home commands and the important commands abroad these officers have been appointed.

6. To ensure a satisfactory ambulance wagon being provided, a prize was offered by the Secretary of

State for War and many firms competed. After exhaustive trials of many patterns, wagons of a thoroughly satisfactory character have now been selected.

7. A special tent (a modification of the Indian pattern E.P. tent) has been designed and made, and has undergone successful trials. Some further alterations have recently been made, and the tent is receiving a final trial before adoption.

Future Action to be taken on the Recommendations.

The provision of further reserves of officers and orderlies is still under consideration. A scheme has been drawn up for the establishment of a reserve of civilian surgeons who will receive military training, and a scheme of special enlistment to provide a sufficient reserve of trained orderlies is also receiving attention.

§ II.—THE AMALGAMATION OF SCIENCE TEACHING
IN THE LONDON MEDICAL SCHOOLS.

The medical session now beginning marks for two of the London medical schools an important step. The schools of St. George's Hospital and of Westminster Hospital are transferring the training of their students in preliminary subjects to central institutions beyond their own walls. In the case of St. George's Hospital students can take up anatomy, physiology, chemistry, and the ancillary subjects either at King's College or at University College, as they please; in the case of the Westminster Hospital the students go to King's College. The prizes and scholarships available for St. George's

students in their early years are in no way affected by this step; they remain open under exactly the same regulations as before, except that possibly the examinations for them will be held away from St. George's. This school, however, is retaining a teacher of both anatomy and of physiology on behalf of exceptional cases where study in these subjects has to be prosecuted at the same time as in the more advanced branches of medical training. This centralisation of preliminary study is in accordance with the University of London scheme, and St. George's and Westminster Hospitals, which are the first institutions to take practical steps in the matter, may be confident of no loss in the future in consequence of their enterprise. It should be a great advantage, apart from the economy involved in giving up classes in anatomy and physiology at a small school, that the teaching of the medical staff can be now devoted to purely clinical subjects, while the laboratories at the disposal of the teachers afford distinct facilities for pathological work and research. Two other of the smaller metropolitan schools of medicine are likely to take the same step in a short time.

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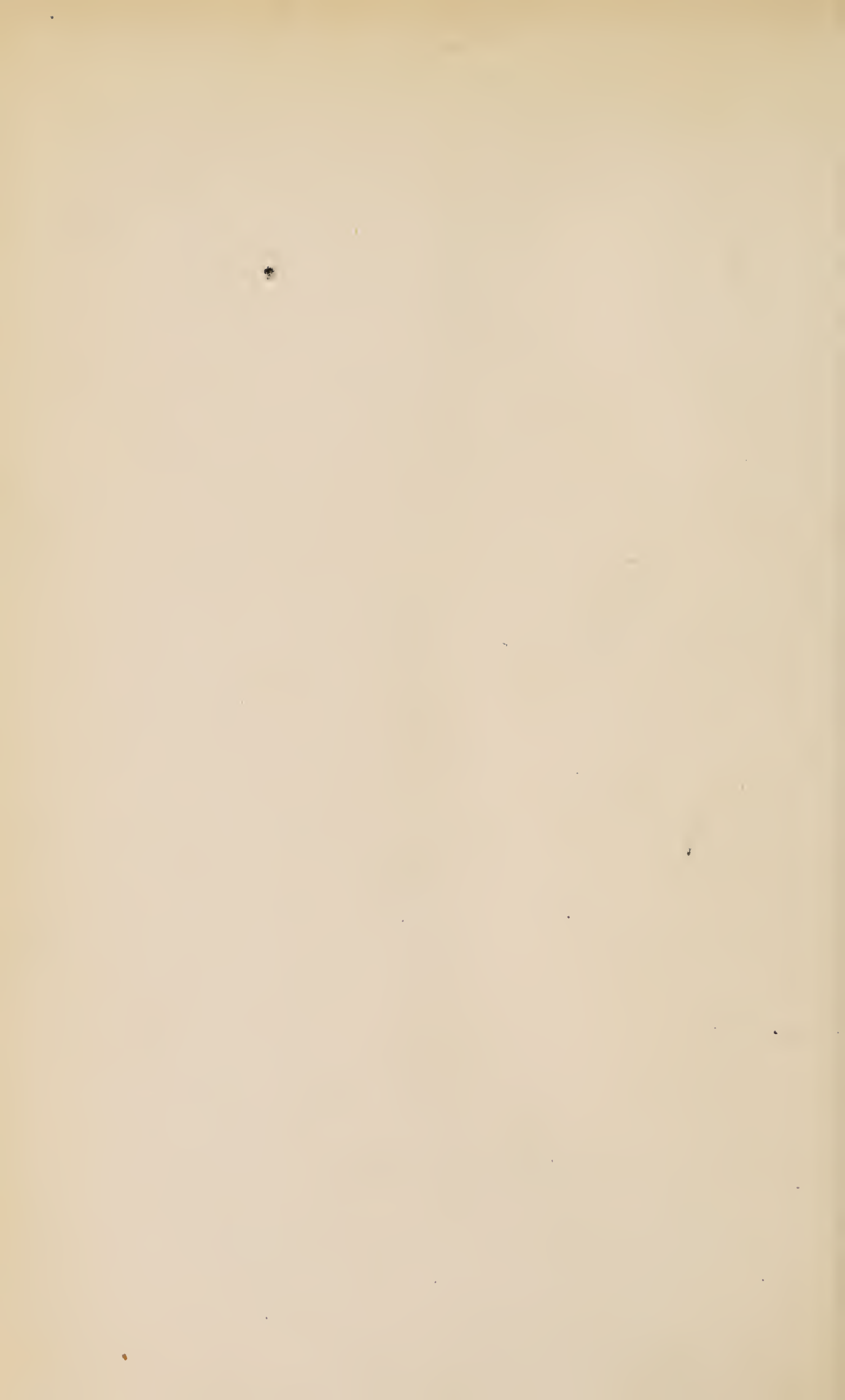
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